Beyond Booking an Interpreter

Developing Cultural Competence in a Collaborative Care Setting

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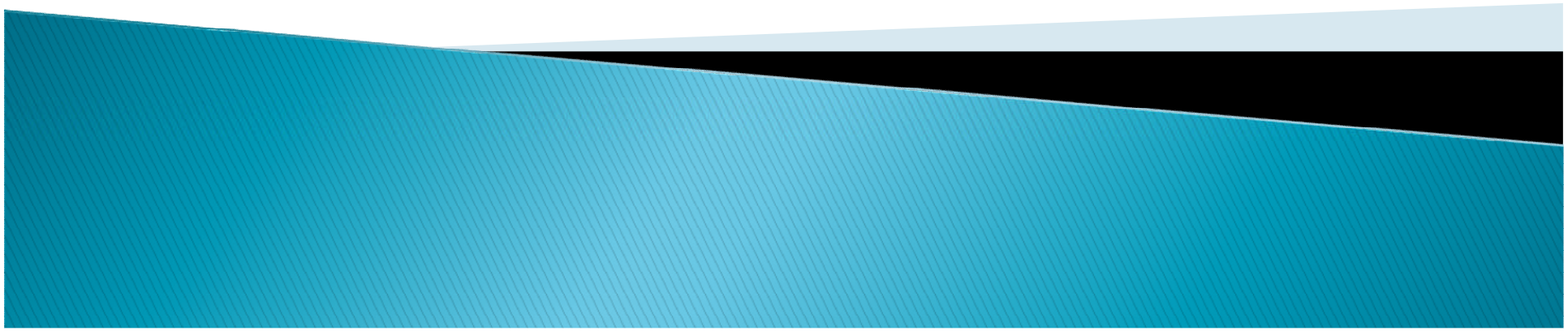
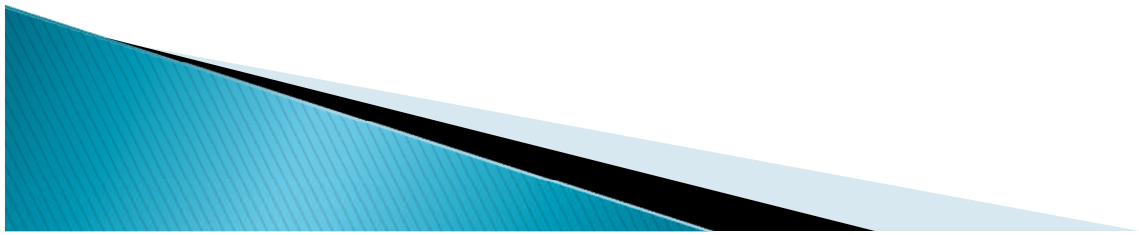


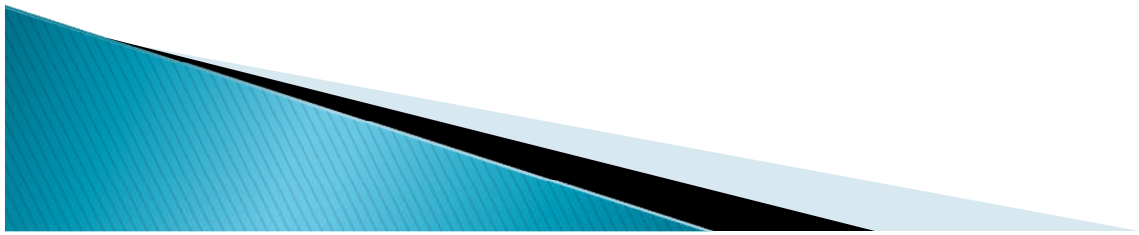
Learning Objectives

- Critically examine the notion of cultural competence
- Apply this to examples from a collaborative care relationship between a Community Health Centre and a Psychiatry Residency training program
- Consider the implications for evaluating a resident's "culturally competent" performance



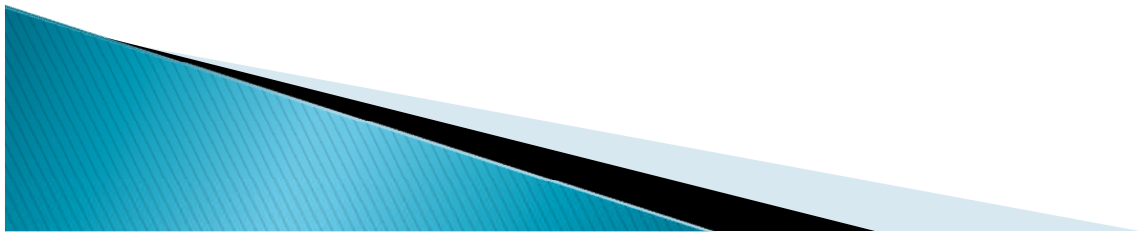
Caveats

- This presentation will raise more questions than it answers!
- It may leave you feeling more unsure than when you entered the room…
- This presentation will aim to help you develop and formulate a first key skill in developing "cultural competence": the tolerance of ambiguity and uncertainty



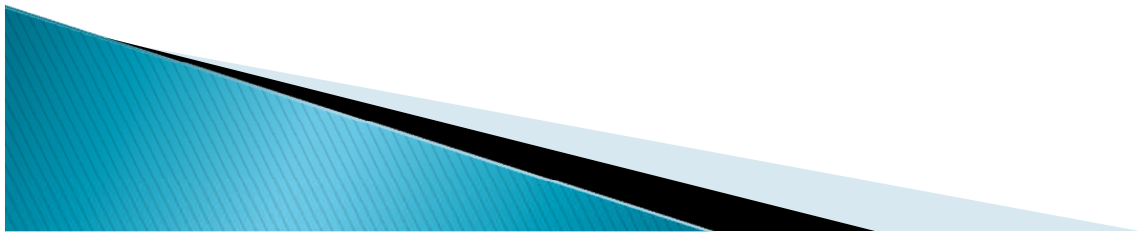
What is cultural competence anyway?

- Not as easy as it looks to define
- Inherently involves defining “culture”
- Where does culture reside?
  - In individuals?
  - In larger systems and contexts?
  - In both?
- To be “culturally competent” seems to assume an ability to articulate culture
- Culture is also relative; depends on an *other*



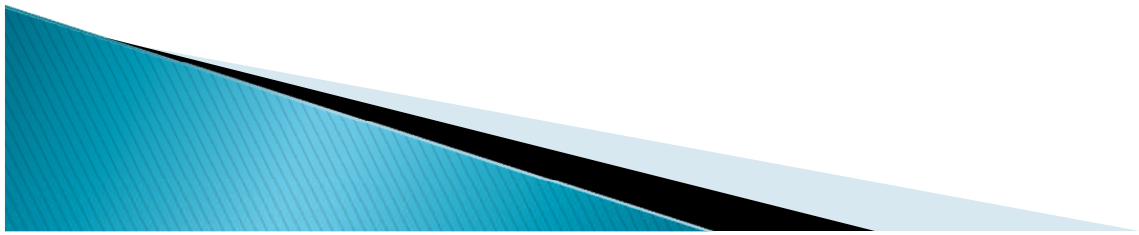
Culture

- “Culture shapes how we explain and value our world. Culture is the lens through which we give our world meaning. Culture shapes our beliefs and influences our behaviours about what is appropriate.” (Núñez, 2000)
- “… maps of meaning through which the world is made understandable” (Bowman, 2010)



And…

- Culture is not static
- "Culture is a moving target and the domain covered by the term as well as its connotations change in response to changes in technology, social structure, identity and human strivings." (Kirmayer, 2006)



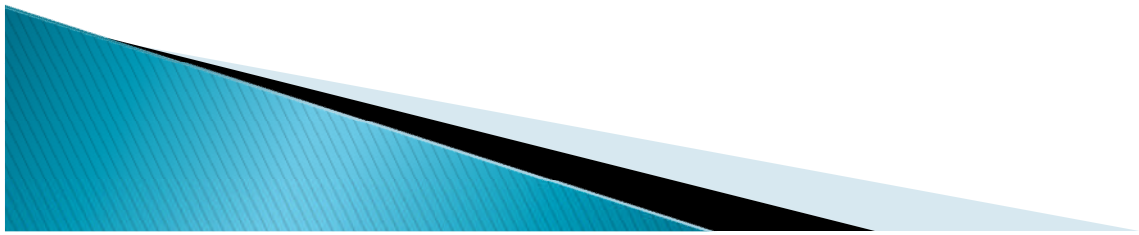
The following we would not consider cultural competence

- A primary focus on two-culture interactions
- The practitioner's job is to figure out the other's culture
- A primary focus on knowledge of customs & language
- A lack of self-reflection on the part of the practitioner about their role and due attention to the context
- Risks ethnocentrism and egocentrism (Nunez, 2000)

Defining "Cultural Competence"

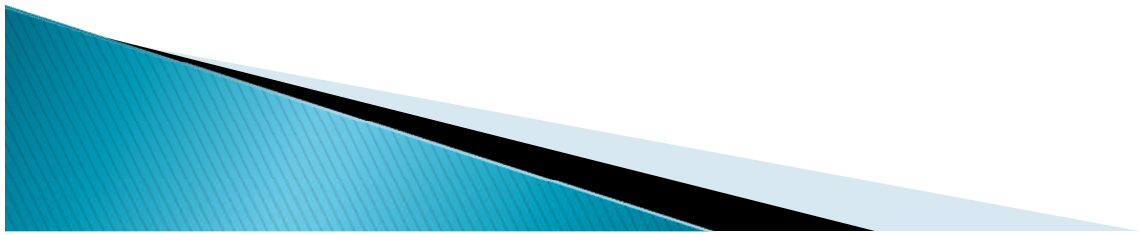
Multiple terms in the literature:

- Cultural competence
- Cultural sensitivity
- Cross-cultural efficacy
- Transnational competence
- Transcultural psychiatry



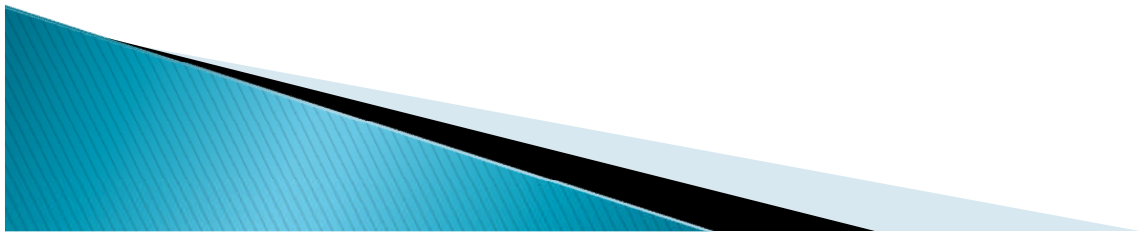
Women's Health in Women's Hands

- Community Health Centre in downtown Toronto
- Primary care for Black Women and Women of Colour from the Caribbean, African, Latin American and South Asian communities



Women's Health in Women's Hands

- "an inclusive feminist, pro-choice, anti-racist, anti-oppression, and multilingual participatory framework in addressing the issue of access to healthcare for our mandated priority populations encompassing gender, race, class, violence, sexual orientation, religion, culture, language, disability, immigration status and socio-economic circumstances"



WHIWH

Client Ethnicity

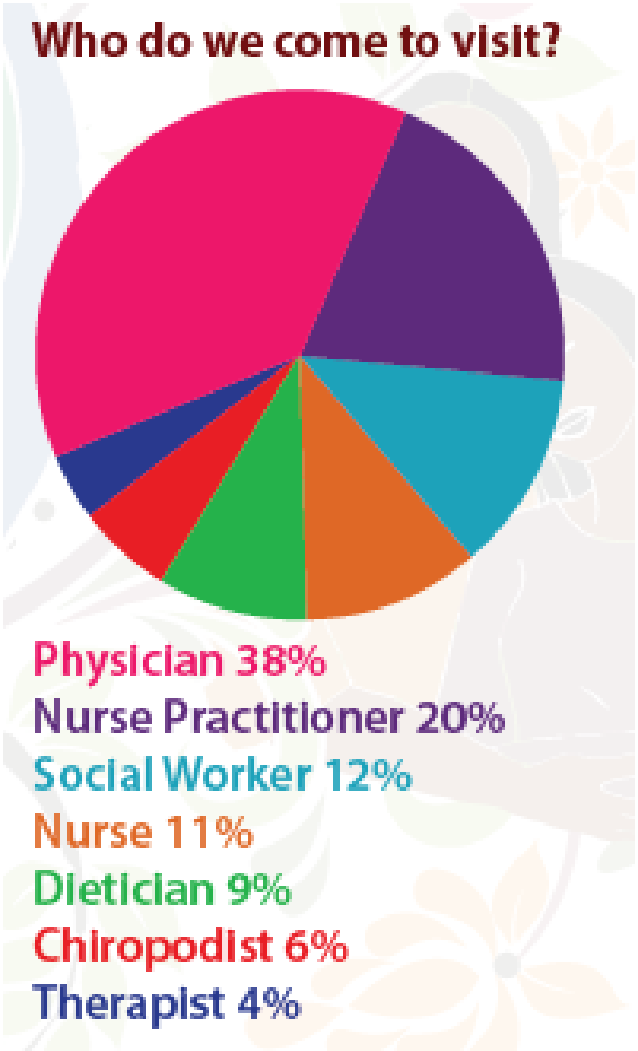
Caribbean – 52%
African – 21%
Latin American – 23%
South Asian – 5%

Top 10 Reasons for Visiting WHIWH

1. Pap Smear
2. Mental Health/Depression
3. Pregnancy
4. Footcare
5. Legal/Financial Problems
6. Issues with Partner
7. Blood Pressure
8. Abuse
9. Diabetes Mellitus Type 2
10. Complete Physical

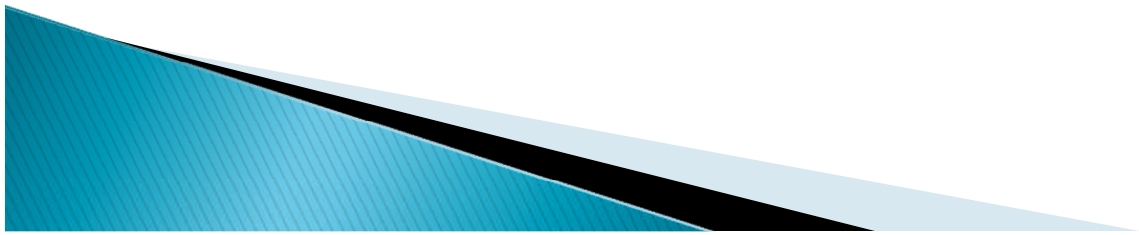
www.whiwh.com - Annual Report 2009

WHIWH


Who do we come to visit?
Physician 38%
Nurse Practitioner 20%
Social Worker 12%
Nurse 11%
Dietician 9%
Chiropodist 6%
Therapist 4%

WHIWH–WCH Partnership

- Developed in Summer 2008
- Clinical care, resident education, and research (including with women who are HIV positive and women who have diabetes)
- WCH offers a training opportunity for senior psychiatry residents at University of Toronto



Resident Elective in Shared Care

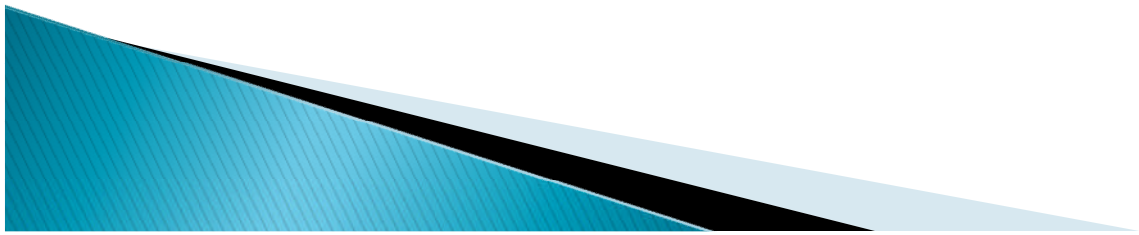
- Throughout final year of training a PGY-5 resident attends WHIWH
- Currently half day on alternate weeks
- 1 ½ hour team meeting prior to 2 ½ hrs of consultations/follow-up with clients
- Residents receive indirect supervision by a general psychiatrist at WCH

Purpose

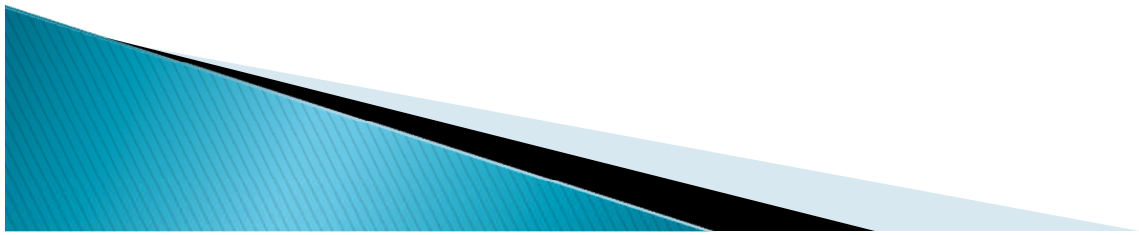
- Provide support to primary care providers through participatory case consultations, didactic teaching, and direct treatment of patients
- Provide an opportunity for residents to experience an alternate model of providing psychiatric care that differs from the usual consultative model and an experience of outreach work with a marginalized population

“Cultural competence” as a process

- An openness to, and a facility with, a process of inquiry and of self-reflection
- Awareness of how the very process of examining culture creates “self” and “other”
- Tolerance of ambiguity and uncertainty

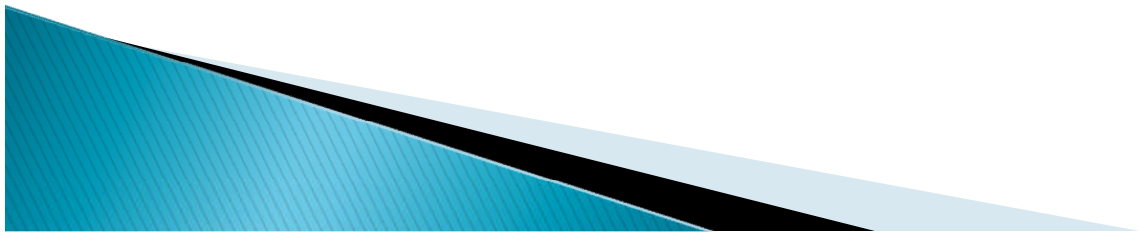


- A “culturally competent” shared care model would examine all the cultures sharing care, including (but not limited to):
  - the individual
  - familial
  - local
  - ethnocultural
  - geopolitical
  - socioeconomic
  - professional



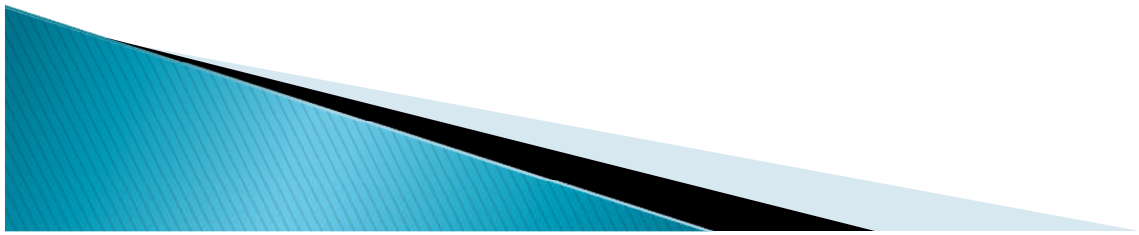
“Cultural competence” as a process

- Ability to build alliances despite differences
- Ethnorelativism: “that there are multiple valid interpretations of behaviour based on diverse beliefs and values” and seeing variance as the norm (Nunez, 2000)
- Awareness of the presence of the medical culture



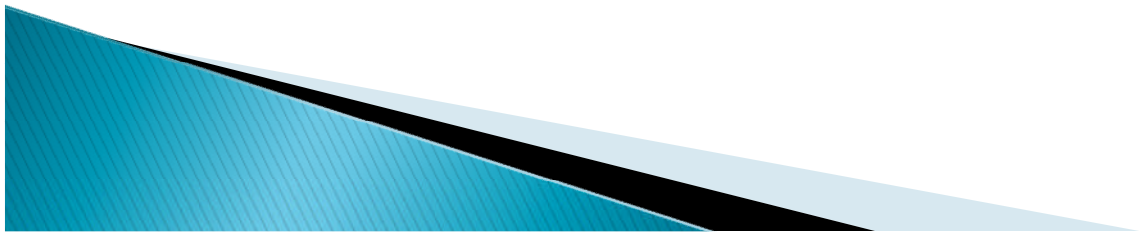
Alternative definitions of cultural competence

- "The skill of using multiple cultural lenses is called cultural competence." (Nunez, 2000)
- "The caregiver is effective in interactions that involve individuals of different cultures and that neither the caregiver's nor the patient's culture offers the preferred view."
- May challenge a culture of medical authority



Mission Impossible!?

- “cultural competence is more akin to psychological mindedness, a quality one aspires toward but can never perfectly achieve” (Fung et al, 2008)

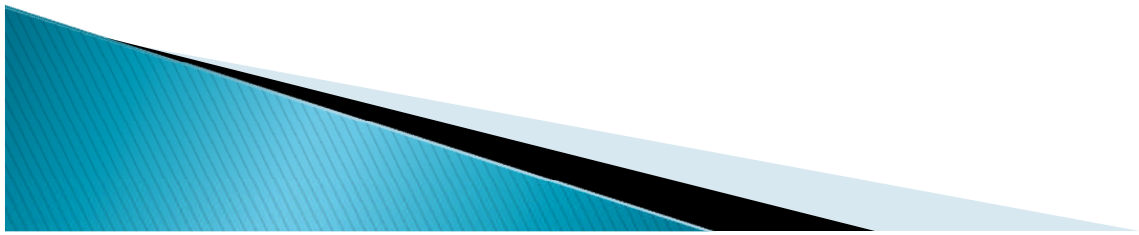


Why this process in this setting?

- Very heterogeneous population
- Only unifying feature of these women is that they access care at this centre
- Assumptions about the client by the physician in a relationship characterized by this power differential can hinder care at best, and can be damaging to the client at worst
- But beware the “clinical anthropologist” syndrome! (Comas-Diaz & Jacobsen, 1991)

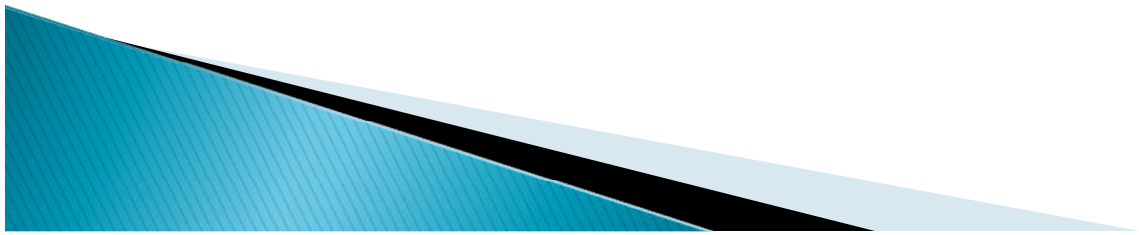
Case example from WHIWH

- 42 year old single woman from Guyana
- Immigrated directly to Canada in late teens
- Never married, no kids, socially isolated
- University educated
- History of childhood sexual abuse
- Felt mistreated by medical professionals; wasn't told reason for referral to psychiatry
- Cognitive + somatic complaints (including pain) with no clear organic basis



Case Example

- What kind of information would you need to elicit in a dialogue with this person (in order to provide health care in a culturally competent manner)?



Some guiding questions

- What do you call your problem (troubles)?
- What name do you give it?
- Why do you think your illness started?
- When did it begin?
- What do you fear most about your illness?
- What are the major problems your illness has caused?
- What kind of treatment do you think you should receive?

Rios & Simpson, 1998

A Transnational Social History for Migrant Patients

- Place(s) of origin and ethnic-group identification(s)
- Premigration education level, occupation, social status
- Premigration state of health
- Personal reasons for departure (elective and/or involuntary)
- Structural contributors (political, economic, social, environmental)
- Presence/absence of persecution, physical/psychological trauma

Koehn & Swick, 2006

Social History (2)

- Who/what was lost in the place of origin or in the process of spatial transition; the extent of loss
- Step-migration circumstances and experiences
- State of health on arrival in receiving country
- Current immigration status (irregular migrants encounter additional barriers and need special assurances)
- Strength of current ethnocultural identity; extent of biculturalism

Koehn & Swick, 2006

Social History (3)

- Current employment, insurance, access to health care, supports, language abilities, discrimination, citizenship
- Current housing conditions, transportation, community climate
- Gender roles, authority relations within the family, views about birth, dying, death, and spirituality
- Contacts and social relationships abroad
- Future migration/transmigration plans

Koehn & Swick, 2006

Social History (4)

- Current state of health and unique health concerns
- Beliefs and practices regarding complementary healing, traditional healers, community-based support systems, and transnational healing

Koehn & Swick, 2006

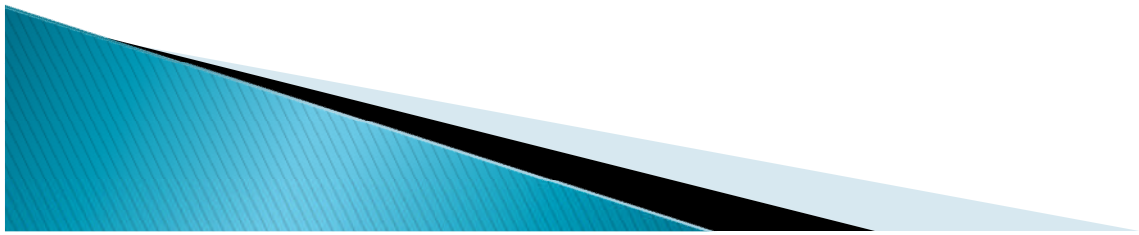
Social History (5)

- Impact of racism and discrimination
- Mutual perceptions of power and position of patient and clinician, including history of relationships between their respective cultural background groups
- Exposure to violence
- Situation of family members left behind
- Plans for reunification, if any

Kirmayer et al., 2008

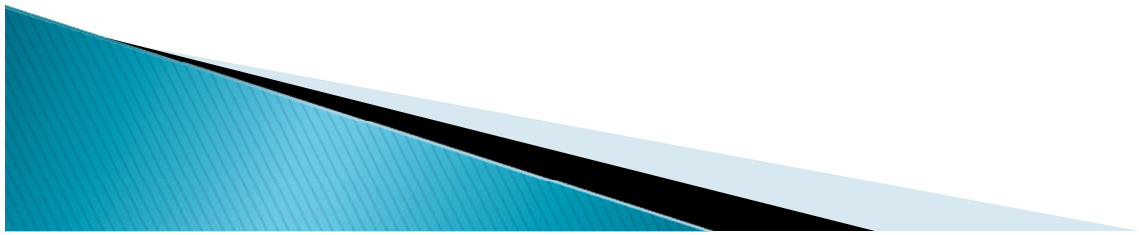
Barriers to this process

- Time consuming
- Easier elicited over multiple visits (not always feasible/necessary in this context)
- We do not always know how much we need to know!
- Language differences
- Potential to re-traumatize in the telling



Other barriers

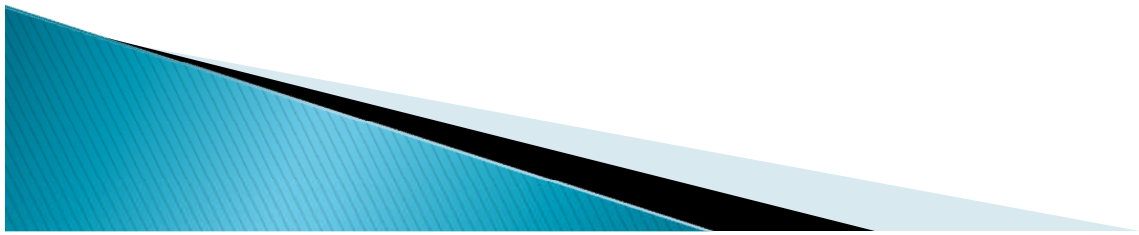
- Culture is not always easily articulated
- Often subtle: preconscious/unconscious
- May be context dependent
- Discomfort with being confronted with one's own stereotypes, assumptions
- It's "airy fairy"



Facilitating this process

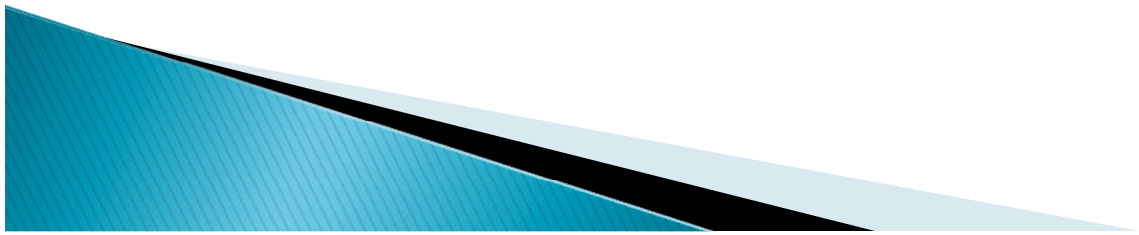
In this context

- Allied health professionals
  - Providing background information
  - As culture-broker
  - Referral “match” between provider and client
- Repeat visits
- Collaborating on what level of detail is necessary for the purpose of the assessment



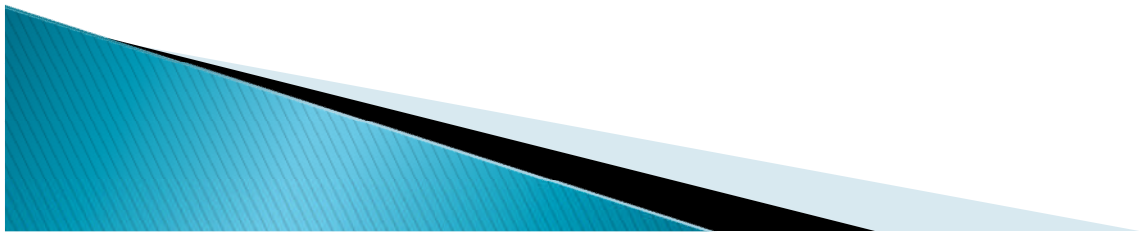
The "DSM Dilemma"

- Diagnosing this way imposes a system of values; a certain language that may not be shared between physician and client
- The "category fallacy" (Kleinman, 1977)
- Worry about pathologizing help-seeking that is normative/understandable within a culture
- May not allow for "idioms of distress"
- Ethnocentric thinking
- Cultural imperialism



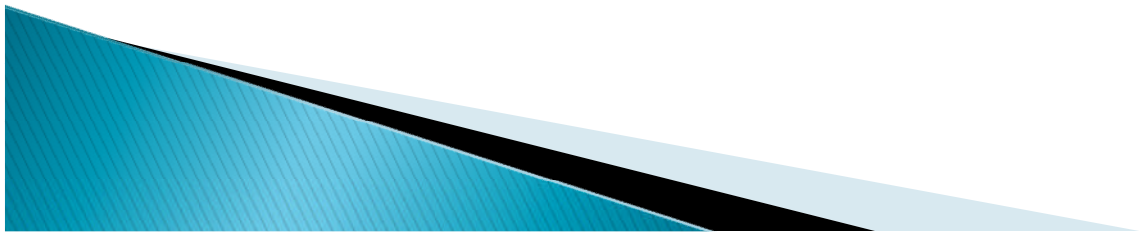
Why is this important?

- Enhances clinical outcome (postulated)
- Advocacy role of physicians
- Respectful of the culture of WHIWH
- Enhances Shared Care with WHIWH (ie interprofessional outcome)



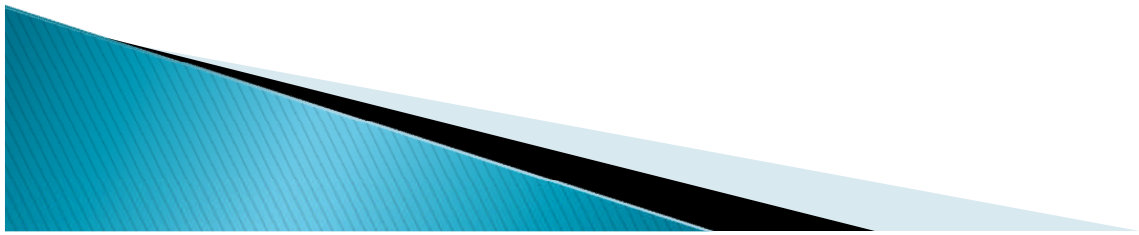
A Case Example

- 45 y.o. female with recurrent psychotic depression, R/O bipolar disorder from St Lucia
- Non-status, living in shelter, no family support
- Variable adherence to medication and becomes extremely ill (catatonic features)
- Recognizes she becomes ill when off meds
- Believes illness due to “lack of blood”; at home, remedies this with orange juice and egg
- Does not subscribe to DSM disease model



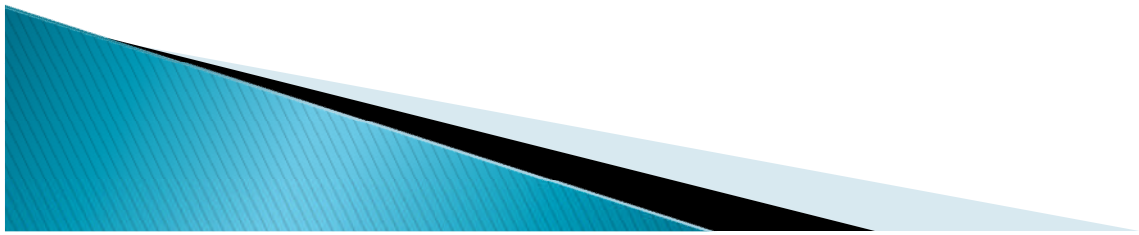
Evaluation

- Requires us to shift from exploratory to evaluative
- But, in parallel to the process we are extolling as “culturally competent”, an educationally competent process includes evaluating the rotation, supervisor and experience regarding how well it/they facilitated the learning process



Evaluation (2)

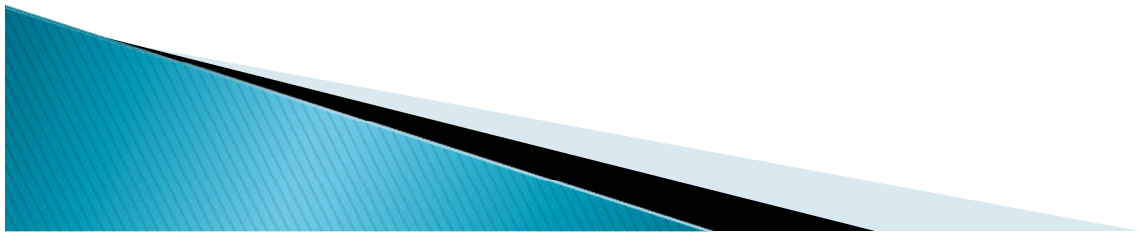
- Did the resident think critically? Did she explore difficult/uncomfortable topics? Was she self-reflective? Did she develop over the course of the year?
- Did the supervisor facilitate all of the above and in particular help the resident tolerate uncertainty, ambiguity, etc?
- A systemic barrier may be supervisor unfamiliarity or discomfort with this process!



References

- Comas-Diaz & Jacobsen, 1991. *Ethnocultural Transference and Countertransference in the Therapeutic Dyad. Amer J Orthopsychiatry, 61, 3, 392-402.*
- Hernandez, et al., 2009. *Cultural Competence: A Literature Review and Conceptual Model for Mental Health Services.* Psychiatric Services, 60, 8, 1046-50.
- Kirmayer, 2006. *Beyond the "New Cross-cultural Psychiatry": Cultural Biology, Discursive Psychology, and the Ironies of Globalization.* Transcultural Psychiatry, 43, 1, 126-144.
- Kirmayer et al., 2008. *Training Clinicians in Cultural Psychiatry: A Canadian Perspective.* Academic Psychiatry, 32, 4, 313-319.
- Kirmayer et al., 2008. *Use of an Expanded Version of the DSM-IV Outline for Cultural Formulation on a Cultural Consultation Service.* Psychiatric Services, 59, 6, 683-686.
- Kleinman, A., 1977. *Depression, Somatization, and the "New Cross-Cultural Psychiatry."* Soc Sci Med, Vol 11, 3-10.

- Kleinman, 1987. *Anthropology and Psychiatry: The Role of Culture in the Cross-Cultural Research on Illness.* British Journal of Psychiatry, 151, 447-454.
- Nunez, A. 2000. *Transforming Cultural Competence into Cross-cultural Efficacy in Women's Health Education.* Acad Med, 75, 11, 1071-80
- Rios & Simpson, 1998. *Curriculum Enhancement in Medical Education: Teaching Cultural Competence and Women's Health For a Changing Society.* JAMWA, 53, 3, 114-120.
- Tseng and Streltzer, 2004. *Cultural Competence in Clinical Practice.* American Psychiatric Publishing, Inc.
- Zweifler & Gonzalez, 1998. *Teaching Residents to Care for Culturally Diverse Populations.* Academic Medicine, 73, 10, 1056-61.



"Perhaps the most availing role for anthropology in relation to psychiatry is to continue to remind us of these dilemmas, to challenge the hubris in our attempts to medicalise the human condition, to encourage humility in the face of alternative cultural formulations of human problems… and to make us uncomfortable with our taken-for-granted professional categories and the tacit interests they represent."

Kleinman, 1987