Working with Gulf Region Nationals: Towards Culturally Competent Mental Health Services

Dr Nora Al Arifi Pharaon
Gain Contact Group, LLC
April 2009

Dr Nora Al Arifi Pharaon

- Licensed Psychologist in NY/NJ
- Certified Group Psychotherapist (CGP)
- Executive Director of Gain Contact Group, LLC www.gaincontact.com
- President of Pharaon Consulting Group, Inc. www.pharaonconsulting.com
- Board President & Co-founder of TANWEER: The Arab American Family Center of New Jersey www.tanweernj.org
- Co-founder & past Executive Director of TAMKEEN: The Center for Arab American Empowerment in New York
- Volunteered for 10 years as UN NGO representative for Society of Psychological Study of Social Issues (SPPSSI)
- Holds a doctorate in Counseling Psychology from Columbia University and masters in Education
- Author of many articles and research papers

Goals of cultural competency training:

- Increase awareness of differences
- Increase valuing of and respect for differences,
- Develop skills for interacting with differences among people.
- Expand cultural knowledge and the dynamics of cultural differences.
- Facilitate the adaptation of services to meet culturally unique needs.
- Offer useful information and tools to better assess and increase cultural competence.

Learning Objectives:

- Participants will develop an increased awareness and sensitivity to different cultures
- Participants will acquire multicultural understanding and learn demographic information on Gulf Region nationals and area populations.
- Participants will increase understanding of communication patterns within the Arab culture

Learning Objectives (cont.):

- Participants will improve their bicultural interviewing, patient assessment, and treatment.

- Participants will develop a "universal skills" approach to cultural sensitivity and equip them with specific questioning and assessment techniques to be used with nationals of the Gulf region.

What is Culture?

An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, or social group and the ability to transmit the above to succeeding generations

Source: National Center for Cultural Competence, Georgetown University

Culture

- Culture can be seen as a pattern of learned beliefs, values and behaviors that are shared among groups. They include thoughts, styles of communication, ways of interacting, views on roles and relationships, practices and customs. Culture shapes how we explain and value the world, and provides us with the lens through which we find meaning.

- Cultural competence in mental health care describes the ability of systems and health care professionals to provide high quality care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs.

Variations in Culture

Cultural variations include the following:

- Race
- Country of Origin
- Native Language
- Social Class
- Religion/Sect
- Mental or Physical Abilities
- Heritage

Cultural variations include the following:

- Acculturation
- Age
- Gender
- Sexual Orientation
- Other characteristics that may result in a different perspective or decision-making process

Cultural Competency Tip: Be Careful to Avoid Stereotyping

- Each individual has a unique personal history, belief system, communication style and health status. What may be true about some or most individuals from a particular region or country may not be true of all individuals from that region or country.
- There are important intra-region and intra-group variations among people from the same country, and cultural variations may be marked among generations.
- Economic status and education can vary greatly among people from the same country.

Culture Gives Context and Meaning

- It is a filter through which people process their experiences and events of their lives.
- It influences people's values, actions, and expectations of themselves.
- It impacts people's perceptions and expectations of others.

Culture Counts

When culture is ignored, families are at risk of not getting the support they need, or worse yet, receiving assistance that is more harmful than helpful

Culture Is Inherent in Family Support Practice

- It informs our understanding of when support is needed.
- It influences how and from whom we seek support.
- It influences how we attempt to provide support.

Five Important Things About Culture:

1. ***Everyone has a culture.*** *It is core to their identity, behavior and perspectives on the way the world works and should be. In fact, everyone lives as part of multiple cultural spheres: ethnic, religious, class, gender, race, language, and others. Culture is not just the group a person is born into. It is possible to acquire a new culture by moving to a new country or region, for example, or by a change in economic status, or by becoming disabled.*

(University of Kansas' Community Tool Box, http://ctb.ku.edu.)

Five Important Things About Culture:

2. ***There is diversity within cultures.*** *While two people may both be Gulf nationals with parents from Saudi Arabia, for instance, a religious Muslim daughter of professionals who lived in Jeddah will have very different cultural norms and perspectives from the son of a tribal man who spent early years in a very rural area in Najd.*

Five Important Things About Culture:

3. ***Cultures are not static.*** *They grow and evolve in response to new circumstances, challenges and opportunities. The ways of being female learned by young girls in Arab Gulf culture, for example, have changed from one generation to another, and as people have moved from place to place.*

4. ***Culture is not determinative.*** *Different people take on and respond to the same cultural expectations in different ways. Assumptions therefore cannot be made about individuals based on a specific aspect of their cultural experience and identity.*

Five Important Things About Culture:

5. ***Cultural "differences" are complicated by differences in status and power between cultures.*** *When one cultural group has more power and status, the norms of that culture permeate the institutions of society as the "right" way. Cultures of less status and power become seen as "other," or even* ***deviant and deficient****. In addition to understanding cultural norms and experiences, service providers and professionals in agencies that work with diverse populations need to be aware of these kinds of cultural biases, both as they play out in the lives of communities, and as they affect the practices and policies of organizations.*

Who Holds Traditional Beliefs?

It is extremely important to remember that some, but not all members of a cultural group adhere to traditional health beliefs or follow traditional health practices. Traditional beliefs and practices may be more common among people who have had little exposure to modern medicine. Even people with more modern beliefs may feel more comfortable and adhere more closely to recommended Western treatments if U.S. doctors offer treatment that does not conflict with the traditional medicine of their patients' home countries.

http://erc.msh.org/mainpage.cfm?file=5.3.0a.htm&module=provider&language=English

Gulf Region

What is the Gulf Cooperation Council?

- The Arabian Peninsula, 630 million acres, consists of Saudi Arabia, Kuwait, Bahrain, Qatar, the United Arab Emirates, the Sultanate of Oman, and the Republic of Yemen. Together, these countries (excluding the Republic of Yemen to be included in 2016) constitute the Gulf Cooperation Council (GCC) created on May 25, 1981.
- A GCC common market was launched on January 1, 2008. The common market grants national treatment to all GCC firms and citizens in any other GCC country, and in doing so removes all barriers to cross country investment and services trade.

Gulf Region: People & Economy

- Total population of GCC countries was approximately 40 million in 2008, which was roughly 12 per cent of the Arab population of Middle East and North Africa.
- The GCC has some of the fastest growing economies in the world, mostly due to a boom in oil and natural gas revenues coupled with a building and investment boom backed by decades of saved petroleum revenues.
- The economy of GCC countries in 2006 accounted for more than 55 per cent of the Arab world's $1.25 trillion economy.

Characteristic of Arab Gulf Society

- Patriarchal (vertical) relationships
- Muslim Majority
- Common collective experiences in Arab societies: political upheavals, rejection from West, chronic conflict with Israel
- Strong need to identify and relate to each other in groups
- Dynamic-family, society undergoing changes vis-à-vis modernization/urbanization , (neo-patriarchy/inhibited growth)

Barakat 1993, Abudabbeh 1996, Sharabi 1991

Characteristics of the Gulf Arab Family- The Cultural Ideal

- Family is the central socioeconomic unit
- Extended family plays important role in child's life
- Patriarchal structure:
  - Father "Lord of the family" – authoritarian
  - Hierarchal stratification based on age and gender. Subordination of women and children
  - Vertical communication patterns (top-down-orders, threats, shaming: bottom up crying, self-censorship, deception)
  - Mother entrusted with child rearing tasks under the father's authority

Characteristics of the Gulf Arab Family-The Cultural Ideal

- Collective identity
  - Individual's main function is to be in service of the family (and its patriarch)
  - Maintaining the family honor and reputation within society is central to Arab psychology
  - Family main source of support (economic/emotional/social) for the individual
  - Self-denial and commitment to family's well being required
  - Breaking the shell of the individual

Characteristics of the Gulf Arab Family- The Cultural Ideal

- Role of children to receive discipline (Adab) and to assume adult economic responsibilities early on
- Prominent Values: Dependency, Shaming, Fatalistic
- There are several values dimensions in which Arab individuals generally struggle with:
  - Shaming vs. Guilt
  - Fatalism Vs. Free will
  - Inter-dependence vs. Independence
  - Conformity vs. Creativity

The Cultural Ideal

- Not predisposed to dependency-rather it is a product of the larger socio-economic constraints on family/society

- Cultural ideal is changing as economic dependence on nuclear family has decreased

Barkaat 1993, 2000, Sharabi 1991

People don't care how much you know, until they know how much you care."

Muslim Culture

Muslim Culture

Culture relates to how people cope with everyday problems and more extreme types of adversity. Muslim culture generally embodies the following attitudes:

- Not to dwell on upsetting thoughts, thinking that reticence or avoidance is better than outward expression
- Suppression of affect with some tending first to rely on themselves to cope with distress.

Muslim Culture (cont.)

- They also appear to rely more on spirituality to help them cope with adversity and symptoms of mental illness
- When they are unable to alleviate their pain or suffering, they more often seek primary care
- They also turn to informal sources of care such as religious figures, traditional healers, family and friends.
- The client's need for expression of intimacy and occasionally the practitioner needs to relax the formality that is the norm in Western helping models.

Muslim Culture (cont.)

- A helping alliance can be developed and maintained through the Muslim conception of trust
- The school system throughout the Muslim world is strongly representative of Muslim culture. Conformity rather than independent thought and creativity predominate.

Marriage and Divorce

- Marriage seen as social contract joining two families
- Parents traditionally arrange marriage according to family interest and maintaining social status
- Patterns changed overtime-increasingly individuals choose their own partner with parent's consent
- No civil marriage-arranged through religious courts
- Interfaith marriages strongly prohibited by all sects

Marriage and Divorce

Muslim Marriage:

- Exchange between the bride's guardian (male) and the bridegroom
- Dowry (mahr) paid to the bride (advance and deferred)
- Endogamy (inter-marriage) are still the rule in Arab world
- Polygamy (plural marriage) is sanctioned by Islam and common practice among many people
- Muslim woman cannot marry non-Muslim man
- Despite the subordinate position women have held within Arab/Muslim society relative to men, Islam is seen as a doctrine that historically gave rights and official social standing to women that was non existent previously.

Marriage and Divorce

- Divorce patterns are significant in affecting the status of women in the Gulf
- Muslims allow divorce though described as most hated of lawful practices
- Various types of Muslim divorces:
  - Revocable, minor and major (3 times)
  - Divorce rates varies; recently suggesting a rise though mostly revocable and minor divorces-often occurring in 'engagement period' prior to actual living together

Based on Barakat 1993;Abudabbeh 1996; Femea 1995

Gender Differences in Muslim Societies

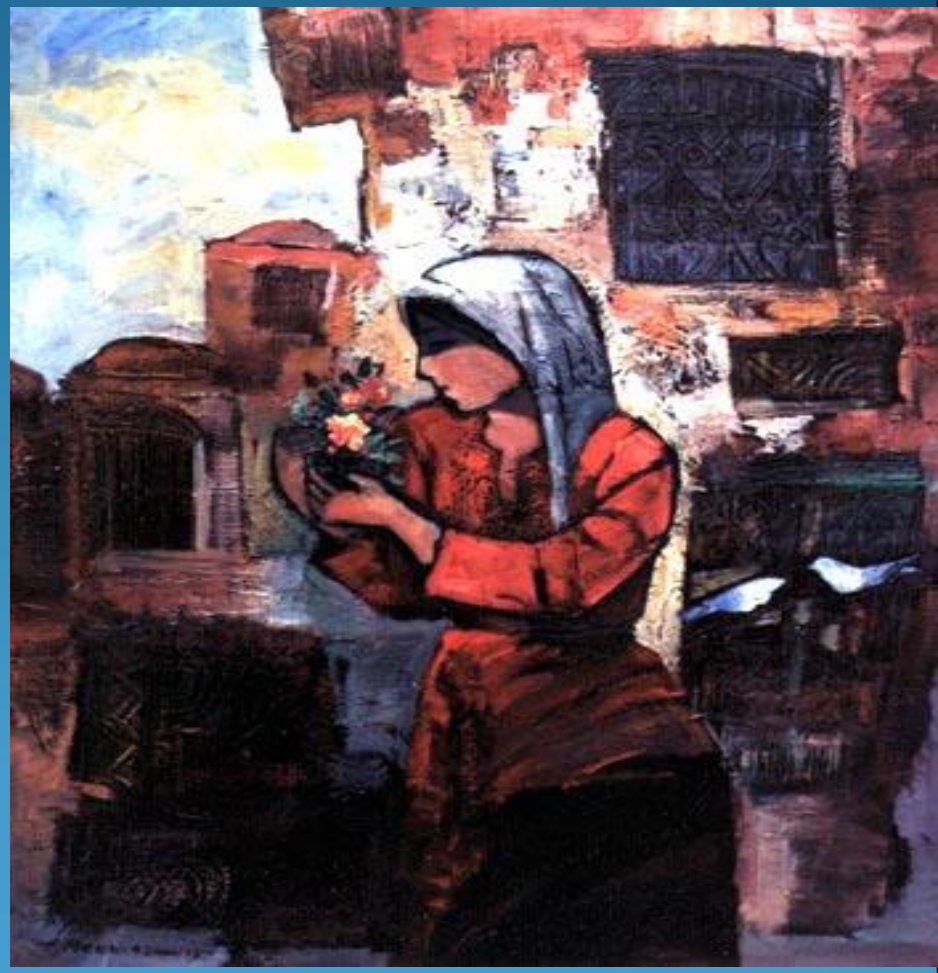
- Gender differences in Muslim societies tend to remain strong, and the social structure is male dominant
- Women from Muslim societies, have been generally viewed as powerless, subservient, and submissive
- Women's social status is strongly contingent on being married and rearing children, especially boys
- Divorced women in Muslim societies suffer emotionally and socially

Gender Differences in Muslim Societies

- Arranged marriages are frequent and women are expected to devote much of their time to caring for their families
- Mothers are known to endure years of marital problems to avoid the stigma of divorce or the prospect of losing their children
- The fear of losing an indigenous "authentic" Islamic culture is used by society to control women further

What is Quality of Care?

The capacity to deliver safe, appropriate, timely, efficient, effective, and equitable treatment

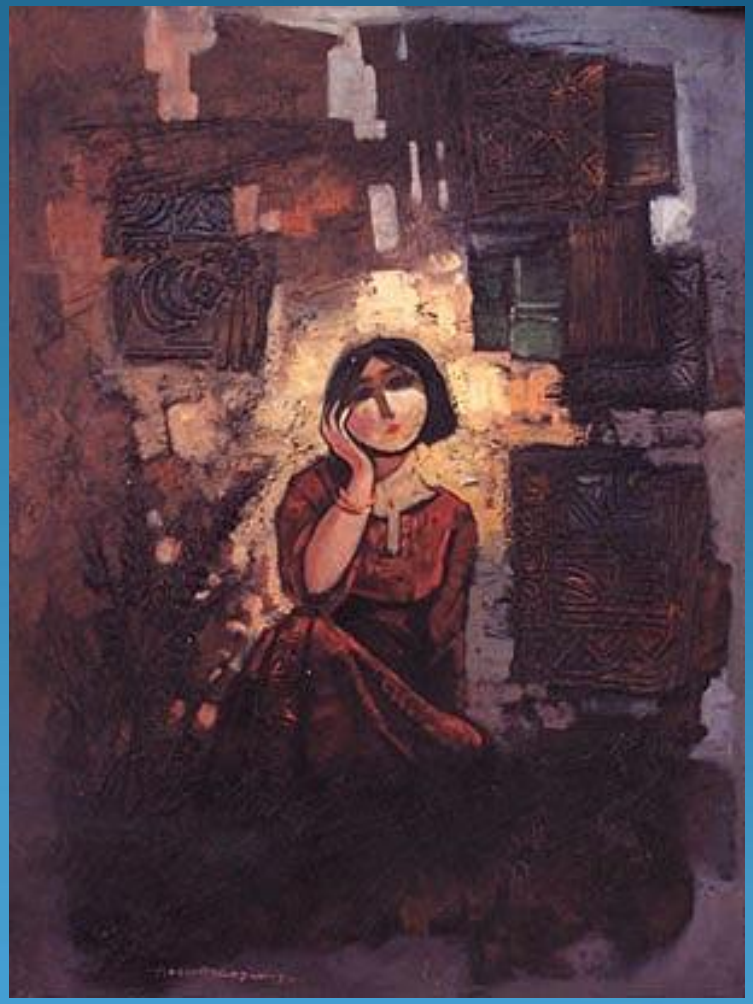


Lack of Awareness of Differences

- **Lack of knowledge** - resulting in an inability to recognize the differences
- **Self-protection/denial** - leading to an attitude that these differences are not significant, or that our common humanity transcends our differences
- **Fear of the unknown or the new** - because it is challenging and perhaps intimidating to get to understand something that is new, that does not fit into one's world view
- **Feeling of pressure due to time constraints** - which can lead to feeling rushed and unable to look in depth at an individual patient's needs

What is Cultural Competency?

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations.



What is Cultural Competency?

Cultural competency is the acceptance and respect for difference, a continuous self-assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations (Cross et al., 1989).

Cultural Competence

Cultural competence is a developmental process. Beyond awareness of subtle expectations or assumptions, there is a need for knowledge about different cultural norms, lifestyle needs, and personal preferences of individuals from different groups.

Operational Definition

Davis (1997) operationally defines cultural competency as the integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual's culture and increase the quality and appropriateness of health care and outcomes.

According to the American Psychiatric Association

Cultural Competence

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of references may incorrectly judge as psychopathology those normal variations in behavior, beliefs, or experience that are particular to the individual's culture. (APA, 1994).

Research on Cultural Competence

- Clinical research continues, but early results indicate that high-quality outcomes are directly affected by cultural competence.
- The doctor-patient interaction cannot be as maximally successful if the patient feels uncomfortable because of the doctor's gender, age, tone of voice, physical gestures, or other behaviors that are meaningless in Western culture but that have cultural significance for Arab culture.
- An equally important element of culturally competent care is expertise in diagnosing and treating illnesses known to have a higher incidence in a given population.

Cultural Competence Education

- Cultural competence education focuses on equipping health care providers with tools and skills to help them overcome some of the major causes of poor quality health care, especially for diverse populations. These include:

- Misunderstandings due to language barriers and poor communication in the clinical encounter, which can lead to mistrust and medical errors.

- Inadequate understanding of patients' beliefs and concerns about taking medications. This can contribute to non-adherence, and poor mental health outcomes

- Doctor shopping, late presentation of disease, and inappropriate use of emergency care, which can arise from healthcare experiences that are not culturally responsive.

Why is Cultural Competency Important?

- The cultural appropriateness of mental health services may be the most important factor in the accessibility of services by Gulf nationals. Developing culturally sensitive practices can help reduce barriers to effective treatment utilization.
- Rapport building is a critical component of competency development. Knowing whom the client perceives as a "natural helper" and whom he/she views as traditional helpers (such as elders, religious institution) can facilitate the development of trust and enhance the individual's investment and continued participation in treatment.

Why is Cultural Competency Important? (cont.)

- The Gulf's population is not only growing, it is changing dramatically. Significant shifts in society are not just about numbers, but also the impact of cultural differences.
- As the cost of healthcare is on the rise , the need to identify a relevant conceptual framework to guide service design and delivery becomes even more evident.

Continuum of Cultural Competence

- How do you react when confronted with a "new" patient situation that does not fit your expectations? Does the situation provoke feelings of anxiety and discomfort? Are you able to assess what is going on within yourself as well as within the patient?
- Do you have strategies to use to gain clarification of a puzzling situation, and to enhance both your own and your patient's understanding?
- Are you able to support and help patients to understand that they are impacted by the same factors as you, regarding cultural differences in beliefs, expectations, behaviors?

Essential Knowledge, Skills, and Attributes to Developing Cultural Competence

- Ensuring the provision of culturally competent services to clients places a great deal of responsibility upon the mental health professional.

- In particular, there are a number of generally expected levels of knowledge, skills and attributes that are essential to providing culturally competent mental health services.

Knowledge

- Knowledge of clients' culture (history, traditions, values, family systems, artistic expressions).
- Knowledge of the impact of social dynamics and poverty on behavior, attitudes, values, and disabilities.
- Knowledge of the help-seeking behaviors of Gulf nationals.
- Knowledge of the roles of language, speech patterns, and communication styles in different communities.
- Knowledge of the resources (i.e., agencies, persons, informal helping networks, research) available for Gulf nationals and their communities.
- Recognition of how professional values may either conflict with or accommodate the needs of clients from different cultures.
- Knowledge of how power relationships within communities or institutions impact different cultures.

Professional Skills

- Techniques for learning the cultures of Gulf national groups.
- Ability to communicate accurate information on behalf of culturally different clients and their communities.
- Ability to openly discuss racial and ethnic differences/issues and to respond to culturally based cues.
- Ability to assess the meaning that ethnicity has for individual clients.
- Ability to discern between the symptoms of intra-psychic stress and stress arising from the social structure.

Professional Skills

- Interviewing techniques that help the interviewer understand and accommodate the role of language in the client's culture.
- Ability to utilize the concepts of empowerment on behalf of culturally different clients and communities.
- Ability to use resources on behalf of Gulf nationals and their communities.
- Ability to recognize and combat racism, racial stereotypes, and myths among individuals and institutions.
- Ability to evaluate new techniques, research, and knowledge as to their validity and applicability in working with Gulf nationals.

Personal Attributes

- Personal qualities that reflect "genuineness, empathy, non-possessiveness, warmth," and a capacity to respond flexibly to a range of possible solutions.
- Acceptance of ethnic differences between people.
- A willingness to work with clients of different ethnic backgrounds.
- Articulation and clarification of the worker's personal values, stereotypes, and biases about his/her own and others' ethnicity and social class. Also, recognizing ways that these views may accommodate or conflict with the needs of clients from different cultures.

Culturally Competent Providers

- Providers need support from organizations and policies to provide cultural and linguistic competence effectively. In addition to support from organizations, providers and practitioners need knowledge and skills to provide culturally competent services.
- Cultural competence requires individual providers at a minimum to (Cross et al. 1989):
  - Acknowledge cultural differences
  - Understand your own culture
  - Engage in self-assessment
  - Acquire cultural knowledge & skills
  - View behavior within a cultural context

Culturally Competent Practices

- Culturally and linguistically competent practices require providers to modify approaches to:
  - Assessment and diagnostic protocols
  - Treatment & interventions
  - Medication protocols
  - Health education & counseling
  - Consulting with traditional/indigenous practitioners & natural healers

Defining Culture in Mental Health Care

There is a need to strengthen the training of mental health practitioners in concepts of culture and strategies for intercultural care

Defining Culture in Mental Health Care

Culture defines the following:

- How mental health care information is received
- How rights and protections are exercised
- What is considered to be a mental health problem
- How symptoms and concerns about the problem are expressed
- Who should provide treatment for the problem
- What type of treatment should be given
- How beliefs and values-including spiritual, relational, and social-impact understanding, communication, treatment, and compliance.

Adapted from the Center for Linguistic and Cultural Competence in Health Care, 2003
http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=3

The *ASKED Framework*

- **A-** Awareness
- **S-** Skill
- **K-** Knowledge
- **E-** Encounters
- **D-** Desire

Campinha-BacoteJ. Cultural Competence in Psychiatric Nursing: Have you "ASKED"the Right Questions?"2002

Challenging the "Isms"

- Ageism
- Sexism
- Racism
- Classism
- Heterosexism
- Ableism
- Xenophobia
- Ethnocentrism
- Relativism
- Scientism

The Need for Cultural Humility

- A lifelong commitment to self-evaluation and self-critique
- Redressing power imbalances
- Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations

Tervalon M, Murray-Garcia J: "Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education, "Journal of Health Care for the Poor an Underserved 1998; 9(2):117-124.

Attitudes Towards Mental Health

- The Arab Gulf community is unfamiliar with the idea of therapy and afraid of the cultural stigma. Somatic complaints is a common presentation.
- The use of religious leader's (imams) as counselors is more culturally acceptable. Traditional methods of healing are very common.
- Most people do not have health insurance.
- Lack of available culturally competent therapists.
- Limited provider awareness of Gulf nationals cultural values and religious traditions.

Attitudes towards Mental Health

- Apprehension towards unfamiliar, authoritarian figures
- The individual's mental illness reflects on the reputation of the whole family-threatens the family honor
- Family (esp. females) provide the main support network for the mentally ill
- Traditionally, individuals and families are discouraged from seeking 'talk' therapy for emotional problems

Muslim Family and Mental Health

- The family unit is sacred among Muslim people
- The extended family members are highly valued, are expected to be involved, and are consulted in times of crisis
- Personal privacy within the family is virtually nonexistent
- Intergenerational conflict and strife impair the normal family function in solving stressful situations

Muslim Family and Mental Health

- The group or family identity remains the focus and the individual remains embedded in the collective identity
- A Muslim woman is more likely to be sanctioned by external-oriented shame, stemming from the attitude of others
- Practitioners working with Muslim women by necessity will come into contact with the family and need to reconsider what might otherwise be seen as a Muslim family's "over involvement" , "overprotection", "blatant codependency", or "enmeshment"

Role of Muslim religion on Clinical Interventions

- Religion is an important context in which problems are constructed and resolved
- Adherents to Islam could believe that an illness is divine punishment
- The concept of psychiatric or psychological problems may be that the origin of them is biomedical, human, or supernatural.
- Religious concepts may often be explicitly incorporated in the helping process

Treatment & Culture

Insensitivity to customs of a particular culture will not only result in misinformed decisions, but may also precipitate resentment. When we experience a form of cultural shock (something outside our normal experience), we have to remember a simple maxim: "What they are doing makes sense to them."

Misdiagnosis can arise from clinician bias and sterotyping of cultural identity

Relationships are built through the Muslim conception of trust

Treatment and Culture

- The first filters: a traditional healer, general practitioner or an internist
- Treatment is most successful when it is short and directive
- Treatment is explanatory and instructional in character
- Notion of time are more fluid and not as structured or determined as they are in the West
- Clients frequently expect to be "cured" of symptoms without having to divulge many aspects of their personal lives

Barriers to Mental Health Care of Gulf nationals

- The Cost of care
- Societal stigma
- The fragmented organization of services
- Clinician's lack of cultural issues
- Bias and racial attitudes of service providers
- Inability to speak the client's language
- The client's fear and mistrust of treatment

Gulf nationals in Therapy: Settings and Boundaries

- Setting is culturally foreign
- Need for psycho-education
- Fluid conception of time-strict time keeping not 'natural' to Arab culture
- Traditional (Western) framework of boundaries and time settings could be maintained
- Need to make therapeutic relationship more cultural-near/personalized
  - Ex. Gift exchange common practice
  - Expression of hospitality-invitations to home, events

Based on Masalha 1998, Dwairy 1996

Gulf nationals in Therapy: Guidelines for culturally sensitive treatments

- Be aware and sensitive to larger political reality and the way it plays out in the therapy relationship-particularly with non-Arab providers
- Contain the tension between collective vs. individual identity
- Systematic view of individual within context of family
- Traditional psychodynamic individual interventions are also applicable with Arab patients.

Based on Dwairy 1996, Masalha 1998

Gulf nationals in Therapy: Guidelines for a cultural sensitive treatment

- Caution against Western bias: Reinforcing values of independence and autonomy as measure of health and well-being
- Goal of therapy may be often to help "discharge heavy burdens of family obligations off the shoulder's of the Arab patient"
  - i.e. help clients achieve a higher level of individuation and autonomy
  - Need to strike a balance between interdependence needs (duties and commitment towards the family) and the need for individuation

Based on Masalha 1998

Clinical Presentation and Culture

- Societal stigma keeps Gulf nationals from seeking needed mental health care
- Gulf nationals with mental problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and do not seek treatment
- Psychiatric patients tend to somatize their emotions and express their feelings in physical symptoms
- Gulf nationals' communications are generally restrained, formal, and impersonal

Clinical Presentation and Culture

- Clients' idioms of distress might rely on a complex system of metaphors and proverbs. They may describe depression as "a dark life" or their pain by saying "my heart hurts"

- Client communication also may appear to be indirect, circular, and non-specific. Self-disclosure, client affect, and self-exploration are often difficult, particularly if they are perceived as risking damage to family honor. These difficulties should not be construed as client resistance.

Clinical Presentation and Culture

Difficulties in communicating and deciphering the client's verbal and nonverbal messages can lead to errant assessments, because of the existence of culture-bound symptoms and syndromes and the choice of approaches and techniques of practice that may be unsuitable for the client's cultural perceptions. This is one of the reasons for early termination of treatment or non use of mental health services

Depression, Somatization and Gulf nationals

- Absence of feelings of guilt, self-deception, social ideas, and feelings of despair and presence of somatic symptoms
- Absence of expression of conflict, whether internal or external, and the expression of negative feelings
- Physical symptoms, however, are accepted as legitimate and morally acceptable expression of pain
- Muslim culture condemns suicide, and clients may not divulge suicidal feelings easily
- Behind the resistance to discuss their difficulties often lies a fear of embarrassment of shaming the family

Potential Failures in Cross-Cultural Therapeutic Process

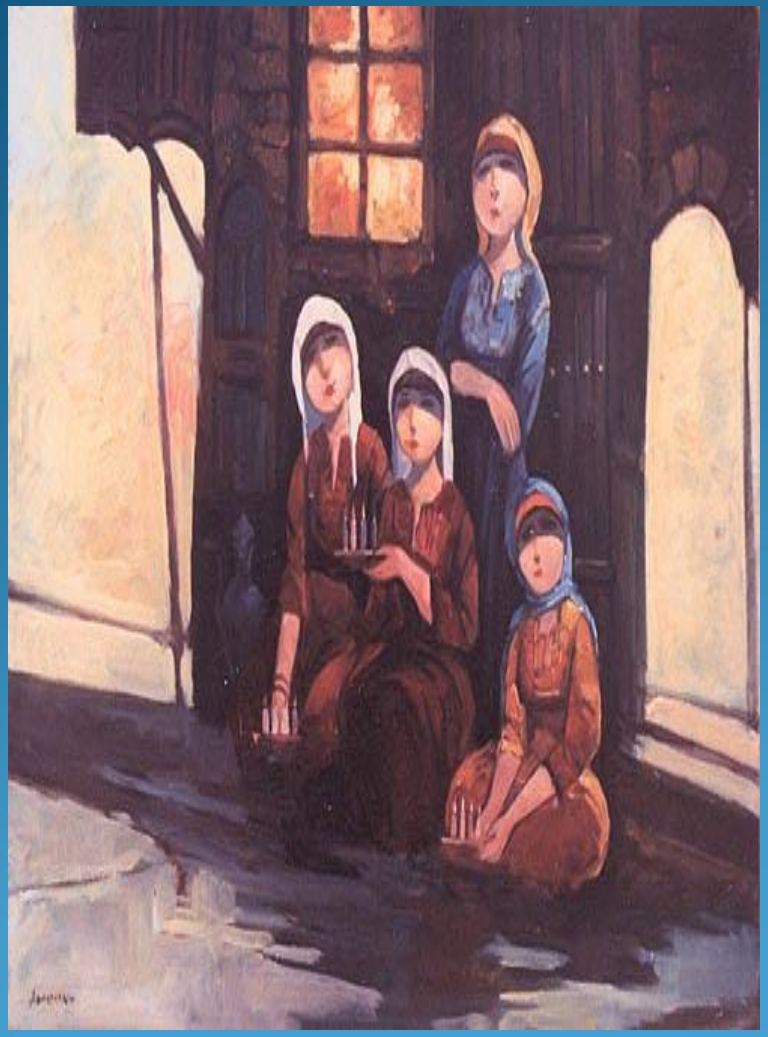
Engagement	*Client Therapist*
• Notices difference	Notices difference
• Perceives social distance	Perceives social distance
• Assumes therapist won't understand	Doesn't acknowledge importance
• Fears being judged	Sees client as stereotype
• Exhibits increased anxiety	Does not address anxiety

Potential Failures in Cross-Cultural Therapeutic Process

Therapeutic Alliance	*Client Therapist*
• Does not develop rapport	Assumes client is resistant
• Feels misunderstood	Does not understand client
• Shows increased mistrust	Fails to respond to mistrust
• Decreases self-disclosure	Sees client as unmotivated or not psychologically minded

Outcome	*Client Therapist*
• Shows frustration and anxiety	Shows anxiety and frustration
• Cancels sessions	Exhibits misalliance; may misdiagnose
• Fails to show for appointments	Perceives faulty treatment planning
• Terminates treatment prematurely	Observes failed outcomes

Communication is Key



Obviously, the most fundamental function of any therapeutic session is communication. We all use verbal and non-verbal ways of expressing ourselves that have been influenced by the culture in which we were raised. These styles can vary dramatically for people from other backgrounds. For example:

Communication is Key

- **Interruption and Turn-taking Behaviors:** Most Americans have come to expect a conversation to progress linearly, while in Arab culture it may be more natural for several people to be talking at once. Listening skills to deal with different turn-taking rules must be developed.
- **Gesturing:** Hand and arm gesturing can vary quite a bit in different cultural backgrounds. In general, extra gesturing should not necessarily be interpreted as excitement since it can just be an ordinary manner of communication, depending on the speaker.
- **Facial Expression:** Variance in this form of communication is also common, and again it is important to not assume that someone is cold or distressed based solely on one's own cultural experience.

Communication is Key

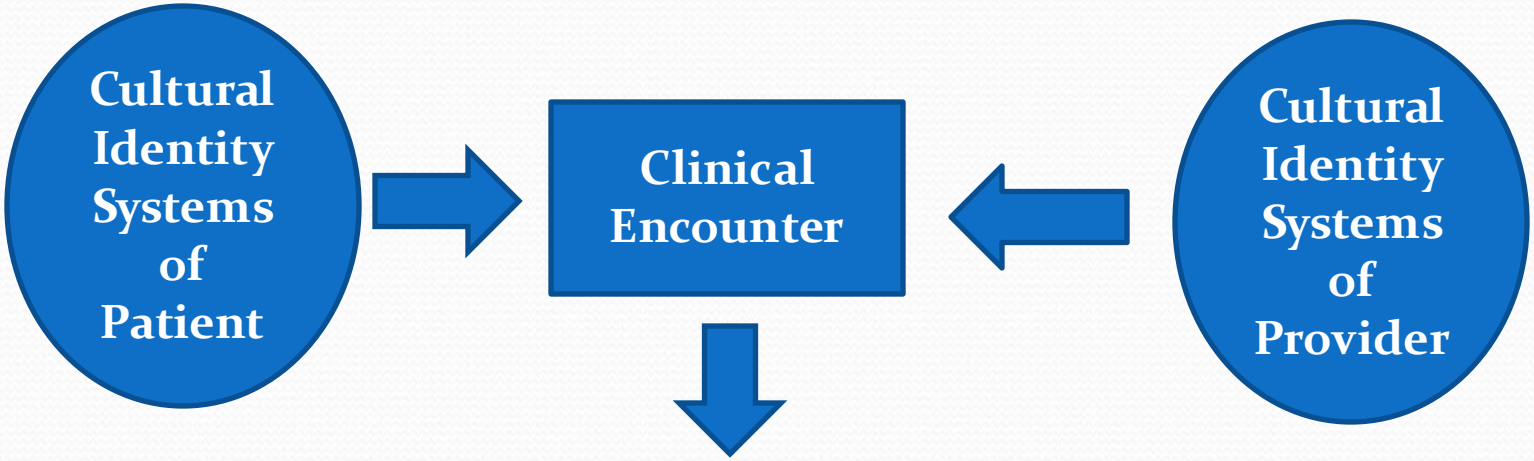
- **Silence:** Americans often find it harder to **tolerate periods of prolonged** silence than do others from Arab culture, and may try to fill it in.

- **Dominance Behaviors:** In the United States, prolonged eye contact, an erect posture, looking down at someone with lowered lids, hands or hips, holding the head high are all examples of behavior that may be interpreted as assertive or even aggressive but can vary in different cultures.

- **Volume:** Irritation often results when culturally different speakers consider differing levels of volume acceptable. It is important to remember that each individual may be reacting based on the rules learned in his/her own background and considered normal by his/her peers.

- **Touching:** Persons from many cultures may perceive someone as cold and aloof if there is not much touching and standing close, while the American may find someone from a different culture a bit rowdy, intrusive, or rude.

Communication Skills & Culture



Issues in the Communication Between Patient & Provider:
Explanatory Models
Stereotyping
Rapport
Satisfaction
Compliance
Responsibility

Hill RF, Fortenberry D, Stein HF: "Culture in Clinical Medicine,"Southern Medical Journal83 (9): 1071-1080, 1990

Eye Contact and Feedback Behaviors

- **Personal Space:** In the United States it is common for people to stand about 3 feet apart when having a personal conversation. In Arab culture, people may typically stand close, which may feel awkward to someone unfamiliar with this style.
- In the US, people are encouraged to look each other directly in the eye and participate actively in feedback behaviors (leaning forward, smiling, nodding, etc.). In contrast, people from Arab culture may show respect or deference by not engaging in eye contact or participating more passively in their body language.

Building Counselor/Client Rapport

- It is important to engage clients and families in a respectful and warm atmosphere. Be sure to pronounce names correctly. Decide if an interpreter or translator is needed. Most importantly, keep the following concepts in mind:
- Determine, given the client's cultural background, who should be present, and who is recognized as a family authority and should be included in key input about the client's current functioning.
- Briefly describe the prescribed treatment and explain the role of each participant. Acknowledge that this may differ from what the client and the family's prior experience with help-seeking would lead them to expect.
- Also explain confidentiality, what it does/does not cover, and how it will/will not be affected by pressure exerted by family members.
- Help the patient/family prioritize their problems and determine what they perceive as the important goals. What are their expectations? How will they know when the goals have been achieved?

Building Counselor/Client Rapport

- Assess possible problems in light of other factors, such as the need for support, employment or stressful interactions with significant others. Provide the necessary assistance in developing and maintaining environmental supports.
- Determine the assets and resources available to the client and family. Has the client, or other family members or friends, dealt with similar problems?
- What cultural resources have they turned to in the past? What was the outcome? Summarize the problem as you understand it and make sure the client knows you understand it.

Building Counselor/Client Rapport

- Discuss the possible participation of family members in treatment.
- Within the family, determine the hierarchical structure as well as the degree of involvement of different members. Focus on the problems produced by conflicting values.
- Explain the specific treatment to be used, why it was selected, and how it will help achieve the client's goals. With the client's input, determine a mutually agreeable length of treatment.
- Discuss possible consequences of achieving the goals for the individual, family, and community.

RESPECT MODEL

R : Respect
E : Explanatory Model
S : Sociocultural Context
P : Power
E : Empathy
C : Concerns and Fears
T : Therapeutic Alliance/Trust

Developed by the Boston University Residency Training Program in Internal Medicine, Diversity Curriculum Taskforce. Published in BigbyJ. A., ed. Cross-Cultural Medicine, Philadelphia, PA, American College of Physicians, 2003, p.

Standards for Cultural Competence

Vignettes: Clinical Exercises

Vignettes: Clinical Exercise

These vignettes are examples of the kinds of cultural challenges and misunderstandings common in situations where service providers are working with children and families whose cultural backgrounds differ from their own. Sometimes these situations cause discomfort; occasionally they are explosive; sometimes they go unrecognized as anything more than a lack of connection. However they play out, they often result in disappointing outcomes. In Arab communities, cultural differences, clashes, and misunderstandings are powerful forces that shape whether people are able to access services. They also determine to a large extent the degree to which programs are able to be successful and reach their goals.

Vignette #1

- Ms. B. is a 35 year-old mother of a 6-year old child who has been exhibiting certain behaviors and mannerisms that created a lot of difficulties within the family. Over the past two years, she has been seeking the help of her pediatrician to identify specialists to provide needed support. Finally, she was referred to a Western therapist who is specialized in the field. After a series of tests, the child was diagnosed with autistic spectrum disorder. The mother was having a difficult time accepting the diagnosis especially since the therapist was stressing the son's long term needs. The therapist constantly emphasized the need for structured activities and one-on-one support without taking much note of the fact that the mother has 4 older children. The child's father is also unavailable and is constantly traveling out of the country. The mother walked out of the therapist's clinic in distress.

Vignette #2

- Ms. M. is a 26-year old woman gainfully employed at one of the big local companies. She is the youngest of three adults daughters who live with their parents. Ms. M presented with complaints of headache, stomach ache and numerous other physical symptoms. At work, she feels constantly put down by her supervisor. She is not able to express herself and finds herself often in tears after the most mundane interaction with her superiors. Ms. M's life at home is equally miserable. Sometimes, she is assaulted by her mother for rebelling against what she describes as strict rules of conduct. Her father is also verbally abusive and sometimes resorts to physical violence.

Vignette #3

- Ms. L. is a 48 year old woman with 5 children. Recently, her husband of 30 years took another wife who was half her age. She stated that her husband not only informed her of his intention to marry but also asked her to bless the marriage. Upon the return of the couple from their honeymoon, her in-laws who lived in the floor above, wanted to maintain the tradition of Friday family get together and insisted that she attends. After the first encounter where she felt completely an outsider, Ms. L developed severe anxiety attacks. She tried to inform her husband and in-laws about her inability and unwillingness to attend those functions, but in vain. Her husband threatened to divorce her if she did not follow the tradition and be a part of the group.

Vignette #4

- Mr. and Mrs. B (30 and 22-year olds respectively) have been married for 5 years with no children. His parents arranged the marriage and maintained continued involvement in their daily lives. This constant interference in their day-to-day decisions put strain on the relationship and drove it to the brinks of divorce. However, his parents would constantly mobilize their efforts and activate their network to neutralize the current conflict. It was only after Mrs. B moved out of the marital home that Mr. B's mother decided to seek professional help for the young couple. She interviewed the therapist and launched her efforts thus maintaining the dynamics that characterized the relationship of the young couple. The therapist was not sure who the identified client was.

Vignette #5

- Race, ethnicity, and language are not the only cultural issues that can affect interactions between the patient and the caregiver. Intra-cultural dynamics can also play a role in disrupting communication patterns and breaking up families. Mr. S, a 26-year old civil engineer, sought the services of a clinician to help him deal with in-laws who made their daughter leave an "incompatible" union. The couple originally met at work and were married after a protracted standoff between the two families. The one-year long and happy relationship had no impact on her parents' decision to break up the marriage once they received new information that confirmed their original contention. All attempts to convince the parents failed and ended with his wife leaving the marital home under extreme pressure.

Vignette #6

- Mrs. D brought her 15-year old daughter to the clinic complaining about her excessive absence from school, increasingly withdrawn behavior, prolonged isolation from family members, and deteriorating academic performance. Mrs. D believes that her daughter has been possessed and sought help from various religious figures she has been referred to by her family. She pressed upon strict privacy and confidentiality and demanded that her daughter's case not shared with anyone at the clinic for fear of rumors spreading out which may ruin her child's prospects for marriage. When the clinician started inquiring about consumption of drugs and alcohol at home, the mother became extremely furious and left the session.

Vignette #7

- Mrs. S is a 25-year old woman who came to the clinic without her husband feeling very distress. She stated that has been married to her cousin for more than 6 months without consummating their marriage. Her marriage has been prearranged by their families since they have been promised to each other when she was 14 years old. She describes her husband as extremely shy with few friends. He keeps to himself when he comes back from work and locks himself up in the second bedroom "chatting" on the internet for extended periods of time. He also keeps her out of his life and rejects her politely when she makes sexual advances towards him. He keeps telling her to be patient with him but she feels that no effort is made on his part. She has not shared any of their marital problems with either of their families and continues to express her satisfaction with the relationship when asked out of fear she may alienate people she deeply cares about.

Vignette #8

- Mr. R is a 55-year old man who came to the clinic complaining about physical symptoms including headache, backache, and poor appetite. He was referred for counseling by his general practitioner who did an extensive physical and ruled out any biological basis for his complaints. Mr. R disclosed that 9 months ago, he lost his wife of 30 years after a long battle with cancer. She left 4 adult children all college age and studying overseas. When asked about his support system, Mr. R maintained that he has none since he isolates himself and hardly answers his personal calls. This has been going on for more than 6 months and he is sure that meds will take care of his problem.

Summary

A framework for culturally competent clinical practice

- **Explanation:** What do you think may be the reason you have this problem? What do friends, family, and others say about your symptoms? Do you know anyone else who has had or who now has this kind of problem? Have you heard about/read about/seen it on TV/radio/newspaper? (If patients cannot offer an explanation, ask what most concerns them about their problems.)

- **Treatments:** What kinds of medicines, home remedies, or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?

Levin et. al. 2000, 189
http://erc.msh.org/mainpage.cfm?file=5.3.0.htm&module=provider&language=English

A framework for culturally competent clinical practice

- **Healers:** Have you sought any advice from alternate or folk healers, friends, or other people who are not doctors for help with your problems? Tell me about it.

- **Negotiate:** Try to find options that will be mutually acceptable to you and your patient and that incorporate the patient's beliefs, rather than contradicting them.

A framework for culturally competent clinical practice

- **Intervention:** Determine an intervention with your patient that may incorporate alternate treatments, spirituality, and healers as well as other cultural practices (e.g., foods eaten or avoided in general and/or when sick).
- **Collaboration:** Collaborate with the patient, family members, other health care team members, healers, and community resources.

QUESTIONS or FEEDBACK

Please email follow-up questions or feedback to Gain Contact Group (nalrifi@gaincontact.com)

Please be sure to complete the evaluation form

Thank you in advance for your feedback!

Post-Training Summary Evaluation

- What are the three most important **things** [**or topics**] you learned during this training?
- Was an appropriate **amount of material** covered during this week? If not, was too *much* material covered or too *little*?
- To what extent do you expect this meeting will make a **difference** in the way you do your job?

Thank you

for your participation in

Working with Gulf Region Nationals: Towards Culturally Competent Mental Health Services