Cultural Competency Development

Promoting Engagement with Black Consumers & Families

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This training event is funded by the Mental Health Services Act (MHSA) in partnership with the Department of Developmental Services.

Objectives

At the completion of this workshop participants will be able to:

- List the factors that lend to racial disparity in mental health service utilization for Black consumers;
- Describe the factors that are associated with positive mental health and thriving in Black Americans;
- Convey an understanding of the intersection of developmental disability, mental health conditions and culture, and how this **influences** consumers' experiences with treatment.
- Identify the clinical skills associated with the development of cultural proficiency in work with Black consumers and families.

Race

(Carter et. al, 2016)

Racial Disparity

Systematic, socially produced important differences in health between groups that are not only unnecessary and avoidable but, in addition, are unjust and unfair.

Whitehead, M. 1992

Disparity in Mental Health Treatment

While clinical interventions remain generally efficacious even when applied across groups of cultural variation there is a significant racial disparity between those helped and those who are not.

Evidence

Average monthly spending on services per consumer by race:

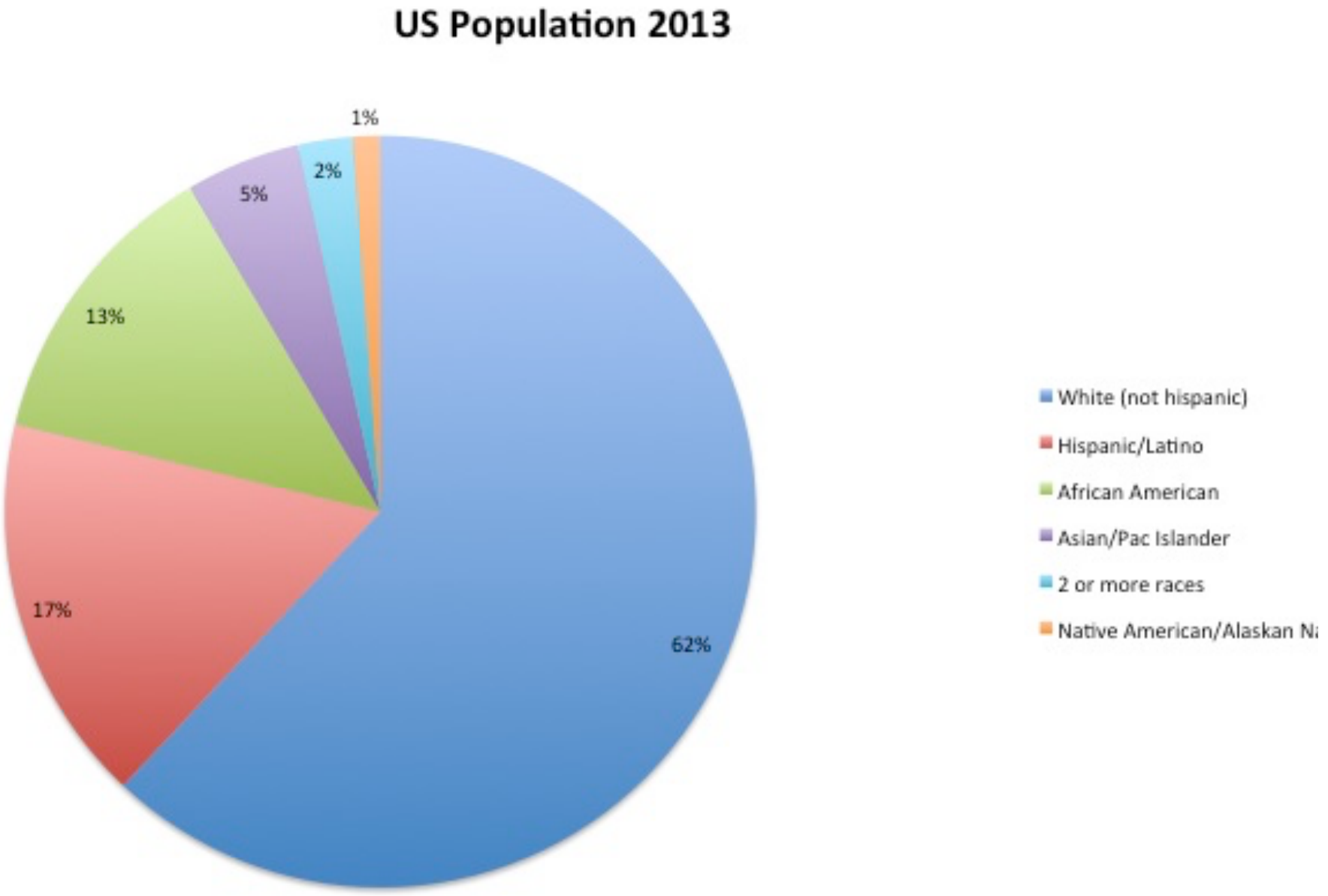
CA	Westside RC
White (32.4%) = $18,171	White (30.0%) = $19,924
Black (9.0%) = $14,255	Black (22.0%) = $17,005
Latino (38.0%) = $8,356	Latino (32.5%) = $11,238

Dept of Developmental Services, 2014-2015 Census and Consumer Population by Ethnicity/Race

Evidence Continued

- Ethnic/Racial disparity in the numbers of people who seek and receive psychosocial services.
- Drop out rate after first session is 50% for minorities compared with 30% for Caucasians.
  - Yet Black Americans tend to be over represented in high-needs populations (homeless, incarcerated, child welfare system, exposure to violence)

Increasing engagement with persons of various cultures involves increasing our capacity to convey understanding and respect for their worldview and experiences.


US Population 2013
1%
2%
5%
13%
17%
62%
White (not hispanic)
Hispanic/Latino
African American
Asian/Pac Islander
2 or more races
Native American/Alaskan Na

Black American Population By US Region

Region	2010	2000	1990
South	23,105,082	19,528,231	15,828.89
Midwest	7,594,486	6,838,669	5,715,940
Northeast	7,187,488	6,556,909	5,613,222
West	4,133,687	3,495,625	2,828,010

Diversity of Black Americans
Income & Class Trends

Family Income	Black Families	White Families
$100,000 and over (upper income)	8.1	14.0
$50,000 - 99,999 (middle income)	23.3	29.6
$15,000 - 49,999 (working class)	41.5	33.5
Under $15,000 (poor)	22.4	11.0
Adjusted Median Income (in 2014 dollars)	**$35,398**	**$56,866**

Diversity of Black Americans

Not all Black communities are distressed.

8.7% of all Black people in U.S. are foreign born.*

*Pew Research Center tabulations of the 2013 American Community Survey

Cultural & Historical

Experiences

Influence (not Determine) a

person's view of self and the

world.

Black Americans:
A Distinct Cultural Experience

- History of Slavery
- Racism and Discrimination
- African Legacy

The Legacy of Slavery and Discrimination in Mental Health

Continues to influence social reality of Black Americans today

Myths of the Past

Blacks have limited mental capabilities

Bell, et al, 1983

Blacks born inferior to Whites

Stanton, 1960

Deutch, 1944

Contemporary Myths

- The Mark of Oppression

  Black families as Matriarchal (Moynihan, 1965)

  Genetic Inferiority (Herrnstein & Murray, 1995)

- The Illusion of Colorblindness

Contemporary Myths

- The Rarity of Depression
- Dementia Praecox Study (Evarts 1914)
  - Black people are less evolved
  - Black people do not have as wide a range of affect
  - Black people experience more severe psych disorder

Major Depression Prevalence Rates

- 2% - 18% General Population
- 7% - 19% Primary Care Population
- 22% - 32% Inpatient Primary Care
- ?% IDD Population

Criteria for Major Depressive Episode

- 5+ of the following present during the same 2-week period & includes either 1 or 2.
  - 1. Depressed mood nearly every day, subjective
  - 2. Diminished interest or pleasure in activities.
  - 3. Weight loss or gain without dieting +/- 5%.
  - 4. Insomnia or hypersomnia.
  - 5. Psychomotor agitation or retardation*.
  - 6. Fatigue or loss of energy

* Retardation in this sense refers to psychomotor and activity slowing

Criteria for Major Depressive Episode Continued

  - 7. Feelings of worthlessness or excessive guilt.
  - 8. Poor concentration, or indecisiveness.
  - 9. Recurrent thoughts of death, S/I, or S/A.
- Criteria for mixed episode not met.
- Symptoms cause distress or func. decline.
- Not due to a substance or GMC
- Not due to Bereavement (Sx severe or > 2mo)

Variations in Depression Sxs in Black Americans

Suspiciousness/Hostility

Cultural Paranoia	Functional Paranoia: Low	Functional Paranoia: High
	Mode 1 ___ **Disclosive to either Black or Non-Black Therapist**	***Mode 2*** ___ **Nondisclosive to both Black And Non-Black Therapist**
	Mode 3 ___ **Disclosive to Black Therapist Nondisclosive to Non-Black Therapist**	***Mode 4*** ___ **Nondisclosive to both Black and Non-Black Therapist**

Cultural Paranoia: Low / High

Functional Paranoia: Low / High

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Less Likely to Report Feelings of Guilt

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Less Restraint in Reporting Intrapsychic Experiences

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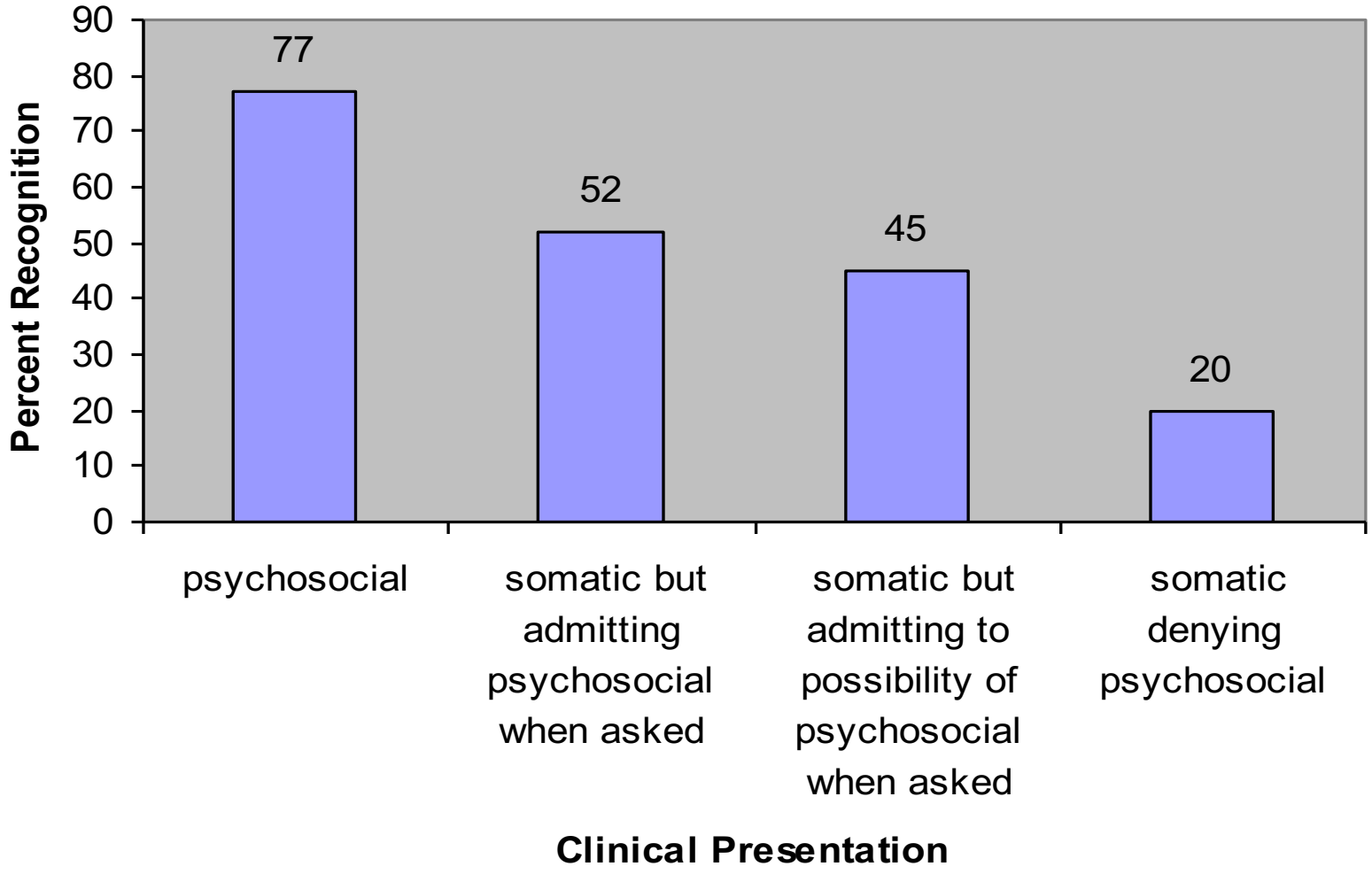
Somatization

Effect of Clinical Presentation on Recognition of Depression



Implications

- Misdiagnosis & Mistreatment
- Fuels suspicion of mental health treatment
- Avoidance or delay of treatment seeking
- More dramatic symptoms set in (somatization)
- Mental health workers less likely to accurately recognize these sxs
- Misdiagnosis & Mistreatment

Maintain An Equal Index of Suspicion for Depression

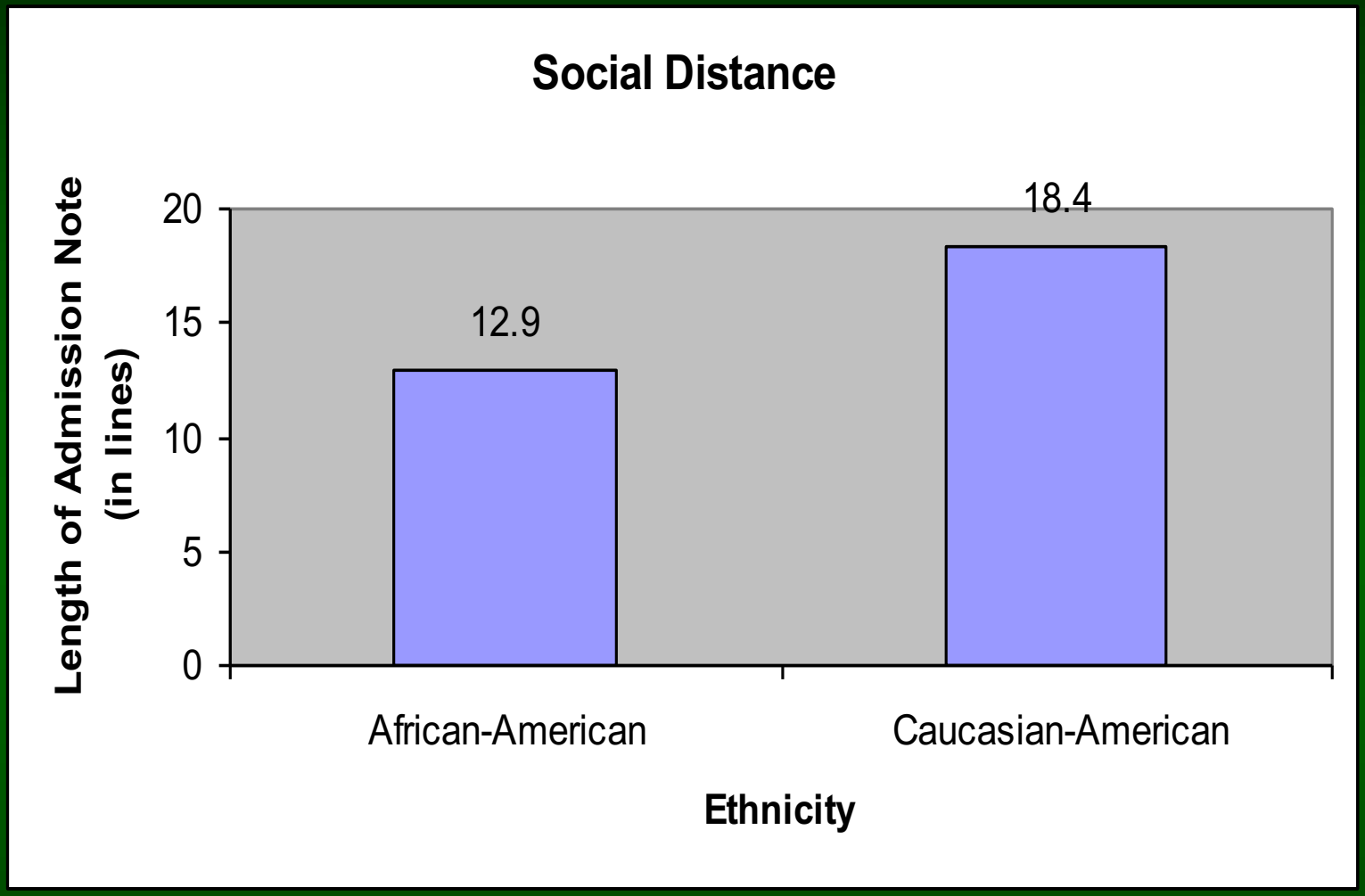
- Recognize Somatic Issues – pain, sleep disturbance
- Loss of Zest for Life – favorite past times lose appeal
- Low Energy
- Suspicion/Hostility/Anxiety – restlessness, constant reassurance seeking, agitation, screaming, shouting.
- Obsessional Thoughts – increased repetitive behaviors
- Extreme Thoughts – delusions
- Observe Caregivers for signs of fatigue

Challenge of Mental Health Work

Engage, assess and treat consumers in light of the psychiatric issues relevant to their context.

Cultural Influences Represented in the Worker

Age (under 65)
Disability-developmental or acquired
Religion (Christian)
Ethnicity
Socioeconomic Status (middle class)
Sexual Orientation
Indigenous heritage
National Origin
Gender



DeHoyos & DeHoyos 1965

Additional Influences

- Cultural influence represented in the worker
- Specific institutional culture of the treatment setting
- Psychosocial Intervention Structure
  - Time orientation (50 minute hour), Client to therapist direction of interaction, Openness, Verbal, Clear distinction between physical and mental well-being

Strengths:
The African Legacy

- Family kinship & collective unity

- The role of religion in the African philosophy of life

Kinship & Collective Unity

"I am because we are; and because we are, therefore, I am"
(Mbiti, 1970)

Kinship & Extended Family Bonds

Slavery – constant dissolution of families

1950's – Discrimination of Social Agencies

Demand for structural flexibility given the social reality.

Functional Extended Family Structure

- Flexible but Clear Boundaries
- No confusion as to the parental or executive figures
- No undermining of parental figures

Family Structure Types

- **Nuclear Family**: parent(s) with children
- **Secondary Member Families**: Parental figures who take in minor relatives (nieces, nephews, grandchildren), peers (siblings, cousins), elders (aunts, uncles, grandparents), or parents
- **Augmented Families**: taking in roomers and boarders
- **Nonblood Relatives**: Play-aunts, play-uncles.

Family Structure Types Dysfunction

- **Nuclear Family**: parent(s) with children
- Problem: Emotional Cutoff- rarely appears as presenting problem. But a family drawn into treatment may be dealing with a significant cutoff from family of origin. (Associated with move up in social class, education, and status.)

Family Structure Types
Dysfunction

Secondary Member Families: Parental figures who take in minor relatives (nieces, nephews, grandchildren), peers (siblings, cousins), elders (aunts, uncles, grandparents), or parents

Problem: Over-dependence on the person perceived as more well off leading to burn out.

Family Structure Types Dysfunction

- Kinship care problems: Ambiguous expectations of duration of kinship care.

Role Confusions

- The Nonevolved Grandmother: Young grandmother (35-45) becomes overly central to family and candidate for burnout given economic realities which lead to increase rather than decrease in responsibility over time.

Role Confusions

- The Parental Child: Delegate responsibility to older child for care of younger children.
- Problem: Parental abdication of responsibility over to older child sacrificing child's normal age-appropriate interactions.

Dysfunction & Role Confusion

Goal is to recognize and support the strength and stability that role flexibility has provided in Black families without perpetuating role confusion.

Religiousness & Spirituality

Spiritual reality inseparable from human existence

Centrality of Black Church

- Prayer as common coping strategy.
  - Positive vs Negative Prayer
- Church Family
  - Provides for social support network for individuals and the family
  - Church Ministries as supports

    Conflict between therapy and religion

Multisystems Model

A problem-solving approach that helps families with multiple problems to focus and prioritize their issues and that allows clinicians to maximize the effectiveness of their interventions.

(Boyd-Franklin & Bry, 2000)

Multisystems Model

- Axis I: The Treatment Process
- Axis II: The Multisystems Levels
- Home based family engagement

Axis I: The Treatment Process

- Step 1: Joining and engaging
- Step 2: Initial Assessment
- Step 3: Problem Solving (establishing credibility)
- Step 4: Use of family enactment, tasks
- Step 5: Information gathering (genogram)
- Step 6: Restructuring family and the multisystem

Communication

Nonverbals

Use of Affect

Eye Contact

Joining

- CONVEY RESPECT: communicate to each family member who attends a session that his or her input is valued and important.
- Common Mistake: Addressing older family members by first name.

Joining

Reluctance in engaging treatment may often mean that outreach work will be necessary to involve key members in the therapeutic process.

Joining - Summary

- Convey Respect
- Connect with significant family members in face-to-face contact
- Communicate that every members input is important and valued

Step 2: Initial Assessment

- **An observational approach considering the following questions:**
- How do family members seat themselves?
- Who is the spokesperson?
- Do members allow each other to speak or do they interrupt?
- Are key members missing from the session?
- What are the boundaries in the family? Are they clear?
- Who has the power in the family? Are they in the room?

Step 2: Addition Questions

- How is the family responding to the worker? Is joining complete? Are key members beginning to trust the worker?
- Should the issue of race be raised at this point?
- Who referred the family? Has worker made a clear distinction between themselves and referring agency?
- How does family feel about being in treatment?

Step 3: Problem Solving

- Multi-problem situations:
- Determine together what is most urgent problem person/family wants addressed first. Be sure goal is realistically achievable.
- Ask yourself who is most bothered by the problem, make sure it is not you.
- Stay focused on solving the one problem first (do not let family's overwhelmedness affect you).

Axis II: Multisystems Levels

- Level I: Individual
- Level II: Subsystems
- Level III: Family households
- Level IV: Extended Family
- Level V: Nonblood kin and friends
- Level VI: Church and community resources
- Level VII: Social Service Agencies & outside systems

Home Based Engagement

- All too often we do excellent office-based treatment with the least powerful members in Black families (young mothers and children).

- Even one well-timed home visit can change the outcome of treatment by engaging powerful members who we may tend to overlook.

Thank You

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