Cultural Considerations in Child and Adolescent Psychiatry

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The onset of psychiatric illness in a child is a life-changing event for families. Families from immigrant and ethnocultural communities often must come to an understanding of their child’s psychiatric difficulties while simultaneously interacting with an unfamiliar health care system and its practitioners.

In this article, we address clinical approaches to the assessment, management, and treatment of mental health difficulties of children and adolescents from immigrant and ethnocultural communities.

**Cultural issues in assessment and treatment planning**
Psychosocial stressors and exposure to trauma contribute significantly to the experiences of families from immigrant and ethnocultural communities. Some families may have experienced organized violence before immigration and are now exposed to violence, racism, and economic difficulties.\(^1\)\(^-\)\(^5\)

The trust and collaboration that are fostered in the therapeutic milieu can help address and buffer the effects of discrimination and ethnic and racial profiling that are often experienced by immigrants.\(^6\)\(^,\)\(^7\)

**Address language barriers**
Families who speak a language other than the dominant language of the health care system should be offered an interpreter. Interpreters facilitate the clinical encounter and, in some cases, act as cultural brokers and contribute to the diagnostic process assisting the clinical formulation by reframing or transmitting essential elements of cultural knowledge.\(^8\)
Avoid asking children and family members to act as interpreters because this can contribute to biased assessments and introduce power imbalances among family members. For example, family members may not wish to disclose sensitive information to relatives who are acting as translators; as a result, this information may not be transmitted during the assessment. Asking children or spouses to act as interpreters can also give them a privileged avenue of communication during assessments, with power to decide what information is transmitted. This can reinforce problematic power relationships (ie, children having more power than their parents or one spouse having more power than the other).

Recognize shifting cultural identities

Family members may have multiple cultural identities that shift over time. The fluidity of culture and acculturation processes needs to be acknowledged. Bicultural and hybrid identities are dynamic elements that shift during child development and across generations, and they need to be explored. Identity issues are best explored through inquiry and addressing our preconceived ideas about the values and experiences of families and children of a particular culture.

Establish a therapeutic alliance

While it is possible that patients have had discriminatory or traumatic experiences, an alliance and the safety of the therapeutic space need to be established before these variables are explored. Pushing for immediate and detailed disclosure can result in retraumatization or a breakdown in alliance building. Similarly, openness to traditional healing strategies and explanatory models of illness should be encouraged; note, though, that these explorations are more likely to be successful after a trusting relationship with the clinician is established.

Recognize differences in cultural values and norms

Psychiatric assessment is influenced by multiple cultural references, in that children, family members, and practitioners may bring divergent values, developmental frameworks, and viewpoints to defining problems.

People from different societies may have differing ideas about what level of hyperactive-disruptive behaviors is considered unacceptable. Such differences affect decisions about what course of action should be taken. For example, in a research study carried out in Lebanon, parents were presented with vignettes of children with attention-deficit/hyperactivity disorder hyperactive/impulsive-type symptoms. Some parents described the children as “dammo hammy,” which translated to “hot-blooded” with a rather positive meaning of masculinity.

The Table cites factors that need to be considered in the assessment of cultural issues and suggests how these factors influence treatment. Each cultural reference can provide a framework or pathway to make sense of the difficulties faced by children and adolescents with mental health problems and their families. Such a framework includes families and social networks that contribute to the clinician’s understanding of the underlying concerns and
cultural differences with the aim of optimizing treatment strategies. For example, families may believe that a psychotic disorder in a child has both a medical cause and a spiritual cause. Treatment might include medication as well as traditional healing. In some instances, our clinic staff has met families who have consulted traditional healers who believe the psychosis is a curse. Such healers may invite family members to pray on a youngster’s behalf, thus mobilizing support within the family.

*Keep an open mind*

The exploration of cultural references in clinical encounters requires a clinical openness. The clinician must have the capacity to reflect on how others see him or her and to be open to seeing himself as a tool in the therapeutic work.13

**The cultural formulation to help guide assessment and treatment**

The American Psychiatric Association developed an outline for cultural formulation in *DSM-IV* to assist in enhancing cultural competence in mental health care. While this formulation outlines the roles of cultural identity, cultural explanations of the individual’s illness, cultural factors related to the psychosocial environment and levels of functioning, and cultural elements of the relationship between the individual and the clinician, child psychiatry assessments are likely to incorporate cultural, systemic, and individual assessments within a developmental model.

A number of authors have commented on how to adapt the cultural formulation to child mental health care practice. Ecklund and Johnson14 provide guidance around how to use the formulation in child intake assessments. This includes culturally relevant probes as well as suggestions that support the development of cultural competence. For example, in our clinics, the practice of children sleeping with their parents is explored to understand whether it is a manifestation of enmeshment and overprotectiveness or a positive endorsement of a cultural parenting style that shows attachment and care.

Other researchers have described the use of the cultural formulation in particular circumstances; for example, with American Indian youth and with Latino adolescents.15,16 In their recent report, Rousseau and colleagues13 underline the limitations of the present cultural formulation outline, because it does not sufficiently address interactions between culture and child development.

**Case Vignette**

Ahmed is a 14-year-old, first-generation Muslim boy of Middle Eastern origin. He was brought for psychiatric consultation with his family after both he and his 2 sisters had been placed outside their home by child protection services because of a concern for his safety. At a medical walk-in clinic, he had reported that his mother had hit him on the head with a slipper. Immediately after his complaint and before a family evaluation, Ahmed and his sisters were removed from their home. Consultation was sought by Ahmed’s child protection worker to clarify cultural issues relevant to the formulation and treatment plan.

Both cultural and contextual issues were reviewed with Ahmed, his family, and his child protection worker. An interpreter was present to foster the building of an alliance. Ahmed’s parents reported during the family interview that they were alarmed when they learned that he had been suspended from school for alcohol use and skipping class. He had always been a good student and had had no previous behavioral problems. Ahmed’s recent behaviors had precipitated this episode of physical punishment in a family that was usually indulgent of both Ahmed and his sisters.

In keeping with the cultural identity of his ethnic group’s families, Ahmed’s parents highly valued their son, where the parental hierarchy generally places a high value on boys, parental authority, school achievement, and family cohesion. Ahmed was negotiating identity issues between 2 cultural worlds: as a devoted, valued son, and as an adolescent growing up in a Western country with a greater sense of autonomy. He was also coping with an internalized negative mirroring image and stigma issues related to 9/11 by attempting to distance himself from his ethnic identity.

Ahmed acted out his ambivalence to parental authority by drinking and defying school rules. The choice of alcohol had a particular cultural significance, given his parents’ Islamic values, which forbid alcohol use. His defiance stemmed from his wish to have increased autonomy. His parents were concerned that increased autonomy would lead to his exposure to the dangers of the street. Ahmed used this bicultural identity strain to negotiate with his parents what he felt was central to a resolution of his conflict around identity and belonging. In addition to understanding ethnic and racial stereotyping, Ahmed understood how child abuse allegations and youth protection involvement could be manipulated so that he could negotiate for increased autonomy. In the meeting, he challenged his parents to give him the relaxed curfews that he wanted. He told them he would not
return home otherwise. The child protection caseworker was able to appreciate the complex shifts of the family’s acculturation process that masked the family’s strengths. Ahmed’s difficulties were reframed, and acting out was seen as a symptom of family and adolescent issues related to autonomy, value systems, and divergent developmental frameworks. In mediating the conflict, the caseworker was able to appreciate the protective issues of parental concerns about peer and community influences. The caseworker concluded that the decision to place the children outside the home had not considered cultural and familial assessment of risk. Following the assessment, a decision was made that the children would return home, and the family agreed to continue in follow-up. Sex, language, race, and cultural identity were identified as factors in alliance building with the family and care team.

This vignette illustrates how different levels of acculturation across generations present complex identity shifts throughout child and adolescent development and that higher levels of acculturation in immigrant children are sometimes associated with greater risk of behavioral problems. Bicultural identity can promote both resilience and flexibility as well as create strain for families and children dealing with cultural value shifts.

The role of school-based services
School-based prevention programs play a key role in promoting the mental health of children from immigrant and ethnocultural communities. Ecological models of intervention that address the whole-school environment are useful because they provide a systemic understanding, help counter concerns about stigma in accessing support, and propose support and training for teachers so that they can help their students without becoming too distressed. This model also insists on parent-school interactions, which should be understood both in terms of cultural differences and also as reflecting minority-majority relations between communities and host country institutions. Classroom-based activities help children assimilate past and present experiences by presenting these as learning opportunities. This facilitates emotional expression of their experiences and promotes positive relationships within the classroom and society. Some prevention programs use specific treatment modalities, such as artistic expression, to support the transformation of past and present adversity through creativity and metaphorical representations and also to foster the development of solidarity among children.

Consultation to remote communities: fostering resilience by supporting community strengths
Remote communities, including First Nations and Inuit, face specific challenges for delivery of mental health care adapted to local sociocultural realities. Resources are often scarce and health care professionals often assume a greater diversity of roles by addressing physical and mental health issues. Culturally specific or local interpretations of illnesses can be misinterpreted, especially if the clinician does not share the same cultural background with the community. At the same time, visiting clinicians can develop an intimate understanding of the community within a long-term relationship as allies of local care providers. The model of collaborative care between professionals in mental health and those working in proximity with communities is a useful one to address the mental health needs of children and youth living in remote communities. Collaborative care models bring together expertise in mental health and in local resources and contingencies, including the frequent extra burden of multiple roles placed on service providers and the unofficial networking roles created internally by communities. Collaborative care offers an opportunity to solidify support for children and their families within their communities. Travel to distant urban settings is reserved for particular diagnostic or treatment issues, because this can add an additional stressor to children and their families. Adapting services to community realities takes into account local strengths and traditional interpretations of mental health problems to co-construct strategies that support the healing of children within their families and communities. A collaborative approach includes addressing the need for culturally responsive services and a commitment to support social, cultural, and economic determinants of health.

Conclusion
Addressing cultural considerations in the mental health care of children from immigrant and ethnocultural communities implies that we address needs for interpreters or culture brokers where necessary and that we see our therapeutic tools and services as well as ourselves, our patients, and our communities in a new light. Cultural psychiatry proposes openness to social and cultural issues allied with good comprehensive general mental health care. Cultural issues are seen as an integral part of the assessment and diagnostic process as well as a key element in the formulation of a
clinical and social intervention plan framed within culturally diverse developmental and social agendas. Culturally respectful services need to be grounded in an ecological framework of care where social, economic, and cultural determinants of health are considered as intrinsic contributors to a person’s well-being.

References: References


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