Cultural Awareness and Responsiveness in Person-Centered Psychiatry

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Abstract

Cultural awareness, knowledge and responsiveness are essential components of person-centered psychiatry. The construct of culture refers to the systems of knowledge, values, institutions, and practices that constitute social systems, including families, communities and societies. Culture and social context influence the causes of psychiatric disorders by creating identities and social positions that may differentially expose individuals to social stressors including racism, discrimination, and forms of structural violence, as well as to positive social support and resources that promote health, resilience and well-being. Culture shapes symptom experience and expression, as well as modes of coping and the social response of others in ways that affect the recognition, diagnosis, and treatment of mental health problems. The course and outcome of psychiatric disorders depend on the interplay between culturally mediated processes of individual psychology, family and community dynamics, and relationships with the larger society. In this chapter, we outline current thinking about the role of culture in mental health and illness and review approaches to integrating attention to culture and social context in person-centered care. We discuss some specific tools and strategies for culturally informed assessment and treatment and outline some issues for culturally responsive mental health services, health care policy, and mental health promotion.

Keywords: person-centered psychiatry, cultural competence, cultural safety, social context, health disparities, structural violence, assessment, diagnosis, mental health promotion

Introduction

Person-centered psychiatry aims to re-orient clinical practice around understanding and engagement with the patient as a person. A crucial aspect of this reorientation is systematic attention to the social world in which the person lives—both in terms of individuals' developmental history and biography and their current life circumstances. Human beings are social and cultural beings: we are born unable to fend for ourselves and spend the first decades of life acquiring language and learning to navigate culturally constructed social worlds. Cooperative social activity is essential for human adaptation and flourishing. For millennia our environments of adaptation have been primarily humanly constructed and our biology and ways of life have undergone co-evolution (Choudhury & Kirmayer, 2009). Hence, medicine and psychiatry must take culture and social context into account in understanding and responding to illness and promoting health and well-being. However, as our social worlds have changed with new technologies, forms of community, and global networks, so too has the nature of culture. Culturally informed psychiatric theory and practice must therefore consider the shifting meanings of culture in relation to new configurations of the social world.

In this chapter, we outline current thinking about the importance of culture in mental health and review approaches to integrating attention to culture in person-centered care. Although some anthropologists argue that culture is a concept that has outlived its usefulness and, indeed, may be a cloak under which various forms of discrimination hide, we believe that the construct of culture has utility in psychiatry, standing for a great variety of social determinants of health and illness experience that are crucial to effective mental health care. Moreover, while some who grant the importance of culture assume

that adopting a person-centered approach will be sufficient for clinicians to elicit all they need to know about cultural and social context from the individual patient, we will argue that systematic attention to culture, guided by relevant conceptual frameworks is essential to obtain a comprehensive picture of patients' lifeworlds and respond appropriately to their health problems and concerns. In this light, we will review current approaches to integrating culture in health care systems and practice with particular attention to person-centered aspects. Finally, we will discuss some specific tools and strategies for culturally informed assessment and treatment and outline some issues for health care policy and mental health promotion.

Crucial to our approach is the recognition that culture is not simply a matter of discrete social factors, values or beliefs, but constitutes the matrix of meaning, discourse and practice through which structures of power, inequality and social position are constructed, legitimated and maintained (Gone & Kirmayer, 2010). As such, understanding the ways in which cultural identities are played out in a given society, community or clinical setting must be central to any vision of a person-centered psychiatry that aims to provide equitable and effective care. Moreover, given that culture provides the language and the settings which people use to negotiate shared values and perspectives, attention to culture is an important bridge between person- and people-centered medicine, which aims to acknowledge the social determinants of health and address the political issues raised by inequalities at local, national, transnational and global levels (Cloninger, et al., 2014).

Thinking About Culture in Context

"Culture" is a broad term that covers all of the humanly constructed and socially transmitted knowledge and practices that constitute a way of life. The meanings of "culture" differ with social, geographic and political context, and have changed over time with the emergence of new technologies, forms of community, and networking. In any country, geographical region or clinical setting, there are specific historical, socio-economic and political factors that define major cultural groupings and highlight some forms of difference and diversity as relevant to the health care system, while others are ignored or rendered invisible. It is important to consider the specific contexts in which concepts and clinical approaches to culture emerge.

For example, much literature on culture and mental health has been produced in the U.S., where diversity is often discussed in terms of the five major ethnoracial blocs defined by the census based on language (Hispanic or Latino), geographic (Asian American or Pacific Islander), indigeneity (American Indian and Alaska Native), and racialized categories derived from the history of the slave trade (African American, Caucasia or White). Of course, such broad groupings cannot capture the diversity within groups. Indeed, later changes in the U.S. census that allowed people to endorse multiple categories have revealed high levels of mixed-identities or hybridity. When people are able to provide their own categories, the predefined categories are "shattered" resulting in a wide array of new identities constructed on many different bases including religion, sexual orientation, occupation or vocation and illness (Good & Hannah, 2015). However, epidemiological data, clinical studies and training materials from the U.S. continue to reference these broad categories, which simply do not make sense in other societies, which have other ways of framing difference and diversity (Kirmayer, 2011).

In societies with a history of colonialism, for example, the identities of newcomers from former colonies may be framed in terms of categories that bear traces of the racism of the colonial past (Fernando, 2012). In other cases, ethnic identity may be suppressed in situations where political ideology sees it as a threat to national unity. The key issue for mental health is that cultural identities depend on local politics and are framed in terms of tensions and distinctions within and between communities. Hence, they are emotionally and politically charged and may be important influences on individual and population health.

Culture is often confused with ethnicity and we need to distinguish constructs of culture, ethnicity and race, which vary across societies with different histories, politics of identity and demographics. Culture generates local forms of identity, including concepts of race and ethnicity. The health implications of these categories must be understood in context. In most societies, culturally constructed categories of identity are associated with major health disparities due to ongoing structural violence (Fernando, 2010). However, these forms of collective identity, even when they are largely imposed by dominant groups within the society, may also constitute communities in ways that allow social support, solidarity and political agency.

Race refers to socially constructed notions of biological difference—usually based on superficial characteristics of appearance (skin color, facial features, hair) that are viewed as markers of intrinsic biological difference. In fact, the characteristics attached to race depend on cultural conventions that hide histories of colonization, slavery, and other forms of structural violence and institutionalized inequalities. Notions of race are commonly incorporated into stereotypes of others and used to maintain

systems of racial discrimination and oppression. Hence, while race is a biological fiction, it is a social fact with major impact on physical and mental health (Gravlee, 2009; Paradies, 2006; Priest et al., 2013).

Culture, race and ethnicity then are not traits of individuals with a particular upbringing or an intrinsic characteristic of some group or community but are constituted by knowledge, practice, values, institutions that form social systems; in effect, culture is a name for a large number of inter-related social processes more than it is a discrete entity or object. The social processes that constitute culture vary at the level of local communities or neighborhoods, nations and transnational networks. At the level of local communities, for example, having neighbors of the same ethic background can promote the mental health of minority groups by improving their social supports and buffering some of the effects of racism (Shaw et al., 2012; Jurcik et al., 2013). At the national level, recognition of minority rights and political voice can empower a community with positive effects on well-being. Internationally, the ways in which specific groups are framed and portrayed in mass media may have powerful impacts on the mental health and well-being of people throughout a global diaspora (Rousseau et al., 2011). In each case, the health implications of identity for individuals depend on the interplay between individual psychology, family and community dynamics, and relationships with the larger society.

The Place of Culture in Person-Centered Psychiatry

The view of culture sketched above has implications for the place of culture in person-centered medicine and psychiatry. In particular, it suggests that many aspects of culture

are expressed in very diverse ways among individuals, so that assumptions about patients based on aspects of their cultural origin or identity are likely to be unfounded. Hence, it is important to explore with each patient not only their cultural origins and background but specific aspects of their knowledge, ways of life and social identities or affiliations relevant to their health care. Although it might be assumed that a thoroughly person-centered approach that explores the individual's perspective will be sufficient to uncover any and all crucial dimensions of culture, systematic attention to culture and context can reveal important aspects of health and illness that may be missed by an approach limited to the individual's perspective. These hidden cultural dimensions include aspects of personal and collective identity, health and illness experience, social determinants of health, and the larger sociopolitical context of the clinical encounter and of population health. Uncovering these tacit dimensions of culture requires systematic inquiry guided by social science perspectives. In this way, the culturally-informed clinician can develop a more complete picture of the patient's lifeworld and predicament. The impact of culture and social context should be explored in the clinical setting to clarify its relevance to the patient's own perspectives and concerns but the process may also uncover issues that enlarge the patient's self-understanding in ways that can be liberating.

Person-centered care begins by engaging patients as people on their own terms and this includes the ways that they understand their own identities. However, identity is not a monolithic construction, but is multistranded or variegated, involving multiple schemas and reference groups that vary with goals and context, including the setting and the perceived identity of the interlocutor. The answers a clinician gets in response to questions about identity will depend on how the question is posed and what aspects are

deemed relevant to the immediate concerns, as well as patients' perceptions of the clinician's own identity, and the safety of the clinical setting. Appreciating patients' cultural background and current contexts requires engaging them at the level of their personal and clinical concerns, which are related to the ways they understand symptoms and illness, their current predicaments, life trajectories, and social positioning. However, self-understanding has its own limits. People may not be aware of many of the social, cultural and contextual factors that shape their identity and health problems.

Indeed the notion of personhood itself is a cultural construction, and there are important variations in what is viewed as central to the person, constitutive of identity and indicative of health or adaptive functioning, as well as positive social, moral, religious and aesthetic values. Table 1 describes some broad cultural variations in personhood relevant to person-centered mental health care. These variations have implications for the assessment of identity, the impact of specific types of stressors, sources of resilience and healing, and the ways in which health, wellness and recovery are conceived (Adeponle, Whitley & Kirmayer, 2012; Ruiz-Casares, Guzder, Rousseau, & Kirmayer, 2014).

Insert Table 1 about here

The most common frameworks in psychiatry, clinical psychology and psychotherapy employ an individualistic concept of the person that emphasizes the importance of self-direction, autonomy and self-esteem (Kirmayer, 2007). On this view, persons are constituted by their individual history, goals and aspirations. In contrast,

sociocentric, familistic or communalistic notions of the person give a more central place to relationships with others. People who understand themselves primarily in these terms will describe the self in terms of their lineage, family, clan or community. They will privilege maintaining the harmony of these social groups and emphasize collective agency and decision-making. Many indigenous peoples around the globe articulate ecocentric views of the person that point to the deep interconnections between the individual and the environment. From the ecocentric perspective, there may be no sharp boundary between the individual and the natural world. For example, Maori traditionally describe their identities not only in terms of clan (a sociocentric notion) but also in terms of the mountains and rivers to which they are connected (Murton, 2012). Similarly, Inuit understand the physical and mental constitution of the person as deeply related to the consumption of country food as the source of the person's strength, integrity and well-being (Kirmayer, Fletcher & Watt, 2008). Finally, many peoples have notions of the person as embedded in and constituted by relationships with spirits or ancestors in what might be termed a "cosmocentric" view of the self. This mode of being might lead people to see their own health and well-being as deeply connected to that of their ancestors and to consult the spirits or ancestors to determine the nature of health problems and to seek guidance when making important health-related decisions.

This list is not exhaustive and these versions of personhood are not mutually exclusive. Cultures, communities and individuals differ in how often, when and where they employ particular modes of thinking about the self. Most people will have elements of each model available to guide their thinking about health and illness. Which schema is foregrounded at any given moment depends on the nature of the problem, the aspects of

symptoms, health and identity they are thinking about, and other social contextual factors.

These versions of personhood are not just abstract conceptual schemas. They are grounded in bodily experiences, and overarching cultural frameworks that include notions about ontology (what the world is made up of), epistemology (how knowledge can be acquired and verified) and morality (what is the right way to live one's life). Because of this variation in concepts of the person, clinicians who aim to respect the patient's personhood cannot assume a completely shared understanding of what is at stake in an illness episode or experience. Health communication therefore cannot simply be a matter of conveying the correct biomedical perspective but must consider the significance for the person, their family, and community of differing ontologies, sources of knowledge, and conceptions of the good.

Culture and the Social Determinants of Health

A second key set of clinical issues concerns the ways that culture influences the social determinants of health. Table 2 lists some key social determinants of health that are shaped by culture. Research on social determinants of health has drawn attention to a broad set of factors related to social inequality, structural violence and the political economy of health care (Allen, Balfour, Bell, & Marmot, 2014; World Health Organization and Calouste Gulbenkian Foundation, 2014). However, the forms of social life vary substantially across cultures. Consideration of this cultural variation can guide the clinician in identifying the particular social stressors or predicaments, causal processes, mediators and mechanisms relevant to care. Understanding the cultural

construction of identity and social position in terms of gender, race, ethnicity, caste, religion or other categories can inform interventions aims to mitigate specific social determinants of health based on poverty, racism, discrimination, and marginalization. Moreover, there is evidence that cultural identity and other culturally configured dimensions of social relationships and environments can constitute determinants of health in their own right. Hence, current models of the social determinants of health need to be enlarged through systematic consideration of cultural diversity both within and between societies. This rethinking is essential for the translation of research on social determinants of health into culturally informed policy and practice both at the levels of population health and clinical services.

Insert Table 2 about here

Culture in Clinical Assessment and Diagnosis

There is evidence that systematic attention to culture and context can impact on clinical assessment and reduce diagnostic error. Understanding symptoms in context may change their significance as indicators of psychopathology. For example, the comprehensive cultural assessment of patients referred by primary care and mental health practitioners to a cultural consultation service resulted re-diagnosis rates of 50-60% across a wide range of patients and diagnostic categories (Kirmayer et al., 2014). In particular, there was evidence for a high proportion of re-diagnoses of patients with psychotic disorders (Adeponle et al., 2012). In most instances, this re-assessment was based on information about personal history, social context and cultural meaning (Adeponle et al., 2015).

Viewing symptoms in context led to re-assigning some patients with apparent paranoid thinking, auditory hallucinations, or psychotic symptoms to diagnostic categories of affective disorder, dissociative disorder and trauma-related conditions. Overall, when social context was considered, there were more frequent diagnoses of adjustment disorder, due to recognition of the importance of social stressors in patients' condition (Kirmayer et al., 2014).

Systematic attention to culture and social context within a multidisciplinary team may also foster exchange of knowledge and perspectives among health and social service professionals (Dinh et al., 2012). In addition to better understanding the significance of symptoms and psychopathology, this leads to a more comprehensive assessment that includes of the patient's social context or predicament, resources, values and treatment expectations.

Approaches to Culture in Mental Health Care

Given the central place of culture in person-centered care, it is essential to incorporate culture and context into clinical assessment, treatment planning and intervention. A variety of approaches have been developed to address the cultural dimensions of care and to understand the person in context (Bhui et al., 2007; Kirmayer, 2012a); each approach has strengths and limitations as summarized in Table 3. Person-centered psychiatry can employ elements of each of these approaches.

Insert Table 3 about here

Mental health literacy approaches assume that lay people may have limited information or be misinformed about mental health and that this can be addressed by education which may include explanations about the nature of mental health problems, everyday coping strategies, mental health "first aid" and appropriate help-seeking. The notion is that if people are well-informed they will be better able to cope and to make appropriate use of the health care system (Jorm, 2012). Increasing the knowledge and skills of community members in general will enable them to respond more effectively to others who face mental health problems. The strengths of this approach include knowledge sharing, patient activation or empowerment, and engagement of the wider community in helping and guiding individuals toward appropriate treatment. Among the potential limitations of the mental health literacy approach is the tendency to view patients' knowledge and illness models mainly in terms of how well they fit the biomedical view, rather than in relation to their personal and cultural meaning and social implications. When patients' understanding is rooted in particular cultural systems of knowledge and practice, merely providing new information may be insufficient to change their values, attitudes and behaviors, and may have unintended negative consequences (Kirmayer & Ban, 2013). For example, efforts to promote a view of major mental health problems as biological diseases, while intended to reduce stigma, may have instilled pessimism about treatability (Kvaale, Haslam, & Gottdiener, 2013). Moreover, given that many barriers to help seeking are structural and economic, focusing primarily on patients' knowledge of mental health may be insufficient (Metzl & Hansen, 2014; Viruell-Fuentes, Miranda, & Abdulrahim, 2012).

Language skill may constitute a structural barrier in health care and limit the ability

to deliver person-centered care. When patient and clinician do not share facility with a common language, communication will be limited and the quality of assessment and care can be severely compromised. In such situations, the use of professional medical interpreters is an essential strategy to improve clinical communication (Leanza, Miklavcic, Boivin, IRosenberg, 2014). While limited language proficiency may suffice to express very basic health needs and concerns, greater skill is needed to convey the complexity of symptom and illness experience associated with mental health problems. Moreover, attention to language history and preference may allow the clinician to appreciate key aspects of patients' identity and social position. Language is key to patients' feelings of recognition, comfort and safety in the clinical setting, as well as the clinician's empathy, access to affect and memory, and ability to mobilize the patient's capacity for creative problem solving.

While language is central to culture, not all of culture is directly encoded or expressed in language; for example, important aspects of culture reside in nonverbal communication and body-practices, family structure and interaction, as well as social networks and community institutions. Understanding these dimensions of culture requires systematic inquiry with patients and others in their entourage or community. To address the broader aspects of culture, clinicians may work with culture brokers or mediators, who have knowledge of the cultures of the patient and the practitioner or institution (Miklavcic & LeBlanc, 2014). The culture broker can act as a go-between, interpreting the meaning of statements and experiences to both patient and clinician by supplying missing or taken-for-granted cultural context and background knowledge. The clinician's ability to understand the patient's social world is crucial for clinical empathy (Kirmayer,

2008).

The strategy of "ethnic match" assumes that addressing cultural dimensions of care can be accomplished by matching patients and services. However, matching can occur at different levels, including the institution, the provider, and the intervention itself. Each level of matching has its own benefits and limitations, which may vary for specific ethnocultural groups and contexts. Matching interventions to the patients' cultural background and expectations can allow them to make use of their own personal and family resources. For example, patients for whom mediation, yoga or other practices are culturally familiar may approach such interventions with positive expectations and find them easier to integrate into their treatment.

Ethnic matching also has important limitations. There is usually wide variation in experience among people from the same ethnocultural group or geographic region. Hence, matching is usually very rough or imprecise and often cannot address all of the salient dimensions of patients' self-identified ethnicity, language, religion, gender, politics, and values. Patients from minority communities may find that matching makes them feel singled out in ways that seem racist or discriminatory or else threatens clinical confidentiality because the clinician is from the same small, local community. In some cases, migrants who have fled persecution may not trust others from their country, community, or ethnic group.

There are also issues for practitioners associated with ethnic matching. While practitioners from similar backgrounds may share some aspects of identity with patients, their education and professional training often distance them from patients. Practitioners who are expected to work with patients from specific communities may feel typecast or

marginalized because they want to be recognized primarily for their technical skills or other competencies rather than their cultural identity (Weinfeld, 1991). Moreover, practitioners who lack frameworks for incorporating cultural knowledge into their professional practice may not make optimal use of their own background knowledge. Finally, in settings with high levels of diversity and many small communities, matching may not be feasible.

Cultural adaptation approaches aim to modify existing evidence-based treatments to better fit the language, culture, expectations and resources of patients from particular backgrounds (Bernal & Domenech Rodriguez, 2012; Huey et al., 2014). The adaptation process involves translation of language, concepts and procedures in ways that balance fidelity to the original intervention and fit with the new population or context. There is evidence that such adaptation can improve treatment acceptability, adherence and outcomes.

Perhaps the most common framework for addressing diversity in mental health services is cultural competence, which is defined in terms of a set of practitioner attitudes, knowledge and skills along with organizational policies and practices that facilitate effective intercultural care (Betancourt et al., 2003). There is some evidence that cultural competence can improve the quality of care and health outcomes in general medicine as well as mental health (Beach et al., 2005; Bhui, et al., 2007, 2015; Renzaho, Romios, Crock & Sonderland, 2013; Truong, Paradies & Priest, 2014). For clinicians, cultural competence includes: (1) awareness of one's own identity, its potential meaning to patients, and how it affects clinical practice; (2) language and communication skills (including skill in working with interpreters); (3) knowledge of issues of racism,

discrimination, structural violence, power, and privilege; (4) specific cultural knowledge relevant to the patient population (e.g. developmental processes, family structure, migration trajectories, explanatory models of illness, healing practices, local community institutions, resources and social issues) (Bennegadi 2009; Hernandez et al., 2009; Kirmayer, 2012a).

Cultural competence outlines a general approach that can be applied to every situation and can promote thinking about mental health problems in context in ways that are relevant to person-centered care for patients from any background. Generic cultural competence begins with professionals' awareness of their own cultural background and identity, assumptions, biases and prejudices. To explore these personal dimensions of their own experience, professionals need safe training and practice settings that encourage self-reflection as well as learning about others' experience, communities, history, traditions and concerns. Applied to institutions and health care systems, cultural competence aims to organize services in ways that respect the language, values and priorities of people from diverse communities. At the institutional level, cultural competence includes establishing collaborative relationships with local cultural communities to identify their needs and concerns and ensure they have a voice in shaping systems and services (Fung et al., 2012).

Despite its popularity as a rubric under which to develop strategies to address diversity, as currently constructed cultural competence has a number of limitations. Discussions of culture tend to locate culture primarily with the designated 'Other', ignoring the sense in which mental health practice itself is an expression of specific cultural values and attitudes. Cultural competence tends to construe culture mainly in

terms of individual characteristics or traits rather than the structure and dynamics of social systems. Cultural competence training sometimes focuses on information about specific ethnocultural groups and this may inadvertently foster stereotypes. A further concern is that the emphasis on the clinician's competence treats the negotiation of values and perspectives as a technical issue outside interpersonal relationships and larger structures of power and domination. In the clinical encounter, the superficial application of principles of cultural competence may create the illusion of mastery rather than opening up a respectful relationship of dialogue, shared inquiry, co-learning and collaboration in decision-making. A person-centered approach to culture and context in the clinical encounter would address this by insisting that the voice and perspective of the individual remain central throughout.

A critical advance in medical anthropology applied the methods of social science to studying the culture of biomedicine and psychiatry. This shift in focus revealed many of the tacit assumptions of biomedicine based on its specific cultural history and values (Good, 1994; Lock & Nguyen, 2010; Napier et al., 2014). Becoming of aware of these assumptions and potential biases opens up a space for recognizing the diversity of illness experience and can encourage the clinician to consider alternative approaches. This self-reflectiveness is the most general aspect of cultural competence. There is a more intimate, personal dimension to this self-reflection and openness that depends on clinicians' understanding of their own identity, both in terms of their own strengths and vulnerabilities, and in relation to how they are perceived by the patient. This will help the clinician develop the sensitivity needed to remain open to patients' perspectives and to address issues related to institutional context and social difference.

Concern about the risk of appropriating the other's cultural knowledge, and reducing culture to a set of impersonal "factors" led medical educators to the construct of cultural humility as corrective stance (Tervalon & Murray-Garcia, 1998). Cultural humility recognizes clinicians' necessarily limited knowledge of any patient's culture and lifeworld and focuses on remaining open to dialogue and learning from the patient in ways that allow mutual understanding and collaboration. Similar concepts have been framed as "intercultural opening" and "cultural safety."

The concept of cultural safety, developed by Maori practitioners in New Zealand (Papps & Ramsden, 1996; Koptie, 2009) and elaborated for other health care contexts, emphasizes the ways in which power disparities and histories of domination make institutions of the dominant society unsafe for minority groups (Brascoupé & Waters, 2009; Indigenous Physicians Association of Canada, 2009). Safety may be especially salient for patients who have experienced silencing, marginalization and discrimination due to gender, sexual orientation, minority status, or other aspects of their identity. But issues of safety are important for all patients who hope to have their unique personhood recognized and respected in health care. Such recognition requires knowledge of the historical and contemporary social, economic and political contexts that create health disparities, social inequities, and structural violence. In clinical practice, cultural safety involves building relationships with others based on recognition, respect, and inclusiveness. The goal is to create safe spaces for meeting, dialogue and collaboration. As with cultural competence, this begins with becoming aware of and working through one's own stereotypes, biases and assumptions. Establishing a safe communicative

situation requires concerted listening to the voice of other, sharing power and control, and learning each other's conceptual language.

The strength of the cultural safety approach is that it recognizes the power differentials inherent in health care with ethnocultural minorities or other vulnerable groups and aims to make structural changes to health services and the clinical encounter to share power and promote patients' voice and agency. The main limitation of the cultural safety construct is that it frames the encounter in terms of vulnerabilities rather than strengths, viewing collective history in terms of conflict and domination rather than resilience. Nevertheless, the effort to foreground histories and enduring structures of inequality is crucial to developing what has been called "structural competence" as a basic component of ethical and effective care (Metzl & Hanson, 2014).

Implementing Culturally Responsive Person-Centered Psychiatry: Implications for Education, Policy and Practice

Sensitivity to cultural dimensions of the lifeworlds of patients, as well as their families and communities is an essential component of person-centered psychiatry. But the clinician and health care system must go beyond sensitivity to respond effectively in ways that meet patients' needs. Elements of each of the approaches described in the previous section can be brought together in forms of culturally responsive person-centered care that address the quality of the clinician-patient relationship, the safety of the clinical setting and practices, and the organization of health care systems and institutions (Kirmayer, 2012a). Specific information about culture and context can then be elicited by practitioners and integrated into the process of comprehensive clinical assessment, case

formulation, and intervention based on conceptual models of the place of culture in psychopathology, healing and recovery (Kirmayer, Guzder & Rousseau, 2014; Mezzich et al., 2010). The process of cultural formulation can be aided by frameworks like the outline for cultural formulation and cultural formulation interview in DSM-5 (Lewis-Fernández et al., 2015; Mezzich et al., 2009). Significantly, DSM-5 recognizes the cultural formulation interview as a part of a person-centered approach relevant to all patients, whatever their background (American Psychiatric Association, 2013, p. 389).

With increasing globalization and migration, communities everywhere are becoming more diverse and policy makers must respond to changing demography. Addressing cultural diversity in population health is important for the effectiveness of health services, social justice and equity, and human rights (Kirmayer, 2011, 2012b). In most regions, policy makers and administrators will need to consider changes in organizational culture within health care institutions to make services culturally accessible and responsive to the all minority groups (Graves, et al., 2007). Patients from diverse cultural and ethnic backgrounds do not represent a homogeneous group characterized by their "difference" from some taken-for-granted norms of the mainstream or dominant local groups, but present multifaceted needs that need careful consideration if person-centered care is to succeed.

The work of the Centre François Minkowska, which provides care for migrants and refugees in the Paris region, illustrates how cultural and person-centered perspectives can be usefully integrated. While the reflex of many clinicians, when confronted with a patient who is culturally or linguistically "different", is to focus on language barriers and cultural references that are unfamiliar, the person-centered transcultural psychiatry

developed by the Centre François Minkowska is not centered exclusively on language or any other sociological consideration, but approaches each patient as a person in all his or her complexity. Social and cultural context is relevant to all patients, who deploy their own cultural meaning systems to make sense of and cope with illness and the clinician must consider these to determine the nature of patients' problems and healing resources. Of course, applying this person-centered approach requires effective communication. This begins with identifying the necessary resources: (1) if clinician and patient share a common language, the principles of person-centered care and culturally-informed assessment can be applied directly; (2) if clinician and patient do not share a common language, it is essential to work with a skilled interpreter; and (3) whatever the linguistic situation, when cultural differences are substantial and resources allow, it is preferable to work with a cultural mediator with expertise in mental health care, who can function as a co-therapist (Bennegadi, 2014).

The knowledge and skills needed for cultural competence must be incorporated into professional training and the elements of institutional cultural competence integrated into health care policy and accreditation standards for health care institutions (Kirmayer et al., 2012). With regard to treatment, service providers must strive to provide care that responds to the diversity of the populations they serve. This requires integrating person-centered services with culturally appropriate resources according to patient need. When establishing services, attention should be given to relevant sociodemographic factors affecting the physical and mental health of ethnic minorities, including employment, housing, education, and migration status.

Each of the social factors that affect health in the clinical setting has broader implications for social policy and prevention. In the case of migrant populations, policy makers must allocate sufficient resources to support public mental health and education about migration and its consequences when developing culturally responsive, person-centered policies. The goal should be to ensure cultural diversity and competence in all aspects of mental health care but also to emphasize that mental health issues are as important as physical health in the policy for social development and long-term integration. In this way, mental health services can facilitate adaptation and social integration for migrants as well as promoting the cultural capital associated with diversity (Kirmayer, 2011).

Conclusion

Concepts of culture and context are central to the conceptual framework of person-centered medicine. Understanding patients as persons who live in social worlds configured by both local and global cultures provides a basis for developing modes of practice that can respond appropriately to each person's values and promote their health and well-being as members of communities. The meanings of culture are changing with both global and local forces, and psychiatry must evolve in response. Globalization has not eliminated cultural diversity but given rise to new hybrid forms. The networking made possible by information technologies has created new kinds of identity and community, new sources of resilience and healing, as well as new pathologies. Addressing these emerging forms of personhood, ways of life, and conflicts requires a broad program of ongoing research and clinical innovation (Kirmayer & Ban, 2013).

The effort to recognize, respect and respond to cultural diversity in mental health care is not only a central pillar of person-centered medicine, it is an important issue for strengthening local and global civil society and human rights. People need to participate in meaningful cultural worlds to realize their capabilities. Addressing diversity through culturally responsive mental health care is therefore a contribution to population health at the levels of the person, family, community and global society.

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Table 1. Cultural Variations in Concepts of Personhood

	Person understood primarily in relation to…	**Health Indicators**	**Illness Indicators**	**Sources of Resilience & Healing**
Individualistic Egocentric	Individual agency, autonomy	Self-efficacy Independence	Lack of self-efficacy Loss of autonomy	Personality traits, knowledge, skills
Communalistic Sociocentric	Collective agency, interdependence	Harmony of the group	Interpersonal conflict	Relationships to family, community, larger society
Ecocentric	Environment (animals, land, natural elements)	Vitality of the environment (biodiversity)	Degradation of the environment	Connection to land
Cosmocentric	Ancestors spirits	Regular observance of spiritual or religious practices	Failure of observances	Rituals to restore respect and moral order

Adapted in part from Kirmayer (2007).

Table 2. Cultural Influences on Social Determinants of Health

Social Determinants	Influence of Culture	Mediating Process or Mechanism
Ethnicity, religion Race Caste	Definitions of social groups Ontologies that essentialize socially constructed categories making them seem natural, necessary or inevitable	Belonging, solidarity Racism and discrimination Marginalization, Subordination, disempowerment
Age Gender Sexual Orientation Education Occupation	Links specific roles and identities to age, gender, sexual orientation, education, occupation and other social statuses	Coherent identity Positively valued roles Social support versus isolation Opportunities to pursue education or find work
Social class	Ideologies that rationalize and maintain structure of communities and social stratification	Economic privation Income inequality

Table 3. Strategies for Integrating Culture in Clinical Care

Strategy	Strengths	Limitations
Mental health literacy	• Educates individuals and communities to identify and respond to mental health problems; • Aims to reduce stigma and improve access to and appropriate use of services	• Assumes that cultural knowledge can be changed by simply providing new information or education • Does not consider local implications of specific explanatory models or practices • May not address structural barriers to care
Language interpreters	• Communication is fundamental to safe and effective health care • Trained interpreters observe ethical standards and provide accurate translation	• Need to go beyond linguistic interpretation to explore meaning of cultural context
Culture brokers or mediators	• Focus on cultural translation can go beyond language to include nonverbal, contextual and community dimensions of meaning and identify important stressors and sources of support and resilience	• Roles, training, and ethical standards for culture brokers not well-established
Ethnic matching	• Practitioners and institutions can present a welcoming face and make use of knowledge of the needs of specific groups to respond appropriately • May be addressed at level of intervention, practitioner or institution with specific benefits	• Matching usually imprecise • May not be able to find match for patients from smaller local communities • May not result in tailored services or intervention • May be stigmatizing for patient and for minority practitioner
Cultural adaptation of intervention	• Interventions can be tailored to be more acceptable and effective for individuals and to mobilize or integrate culturally-grounded coping strategies	• Cultural adaptation is time-consuming and costly • Effectiveness of adapted intervention may be uncertain and require additional evaluation
Cultural competence of clinician	• Focus on clinician fits with professionals' emphasis on knowledge and skill acquisition • Generic skills can be used with diverse and changing population across different settings	• Tends to locate culture with the patient and expertise with the clinician • May not sufficiently emphasize issues of power, structural violence and inequality
Cultural competence of institution and health care system	• Organizations that make efforts to address culture may be seen as more receptive and	• May emphasize form rather than substance in terms of structural organizational

	responsive by ethnocultural communities • Can change local institutional culture in ways that foster competence at all levels of service delivery	change • Requires resources for institutional re-organization
Cultural safety	• Addresses issues of power and inequality rooted in historical and structural violence • Focuses on safety of systems, institutions, clinical settings and encounter • Emphasis on power sharing and dialogue	• Framed in terms of vulnerability rather than strengths
Cultural formulation	• Use of specific tools and procedures to elicit and organize clinically relevant cultural information (e.g. DSM-5 Cultural Formulation Interview) • Emphasis on understanding context in systematic way • Relevant to all patients	• Issues of how to integrate information into clinically useful formulation

See: Kirmayer (2012a)