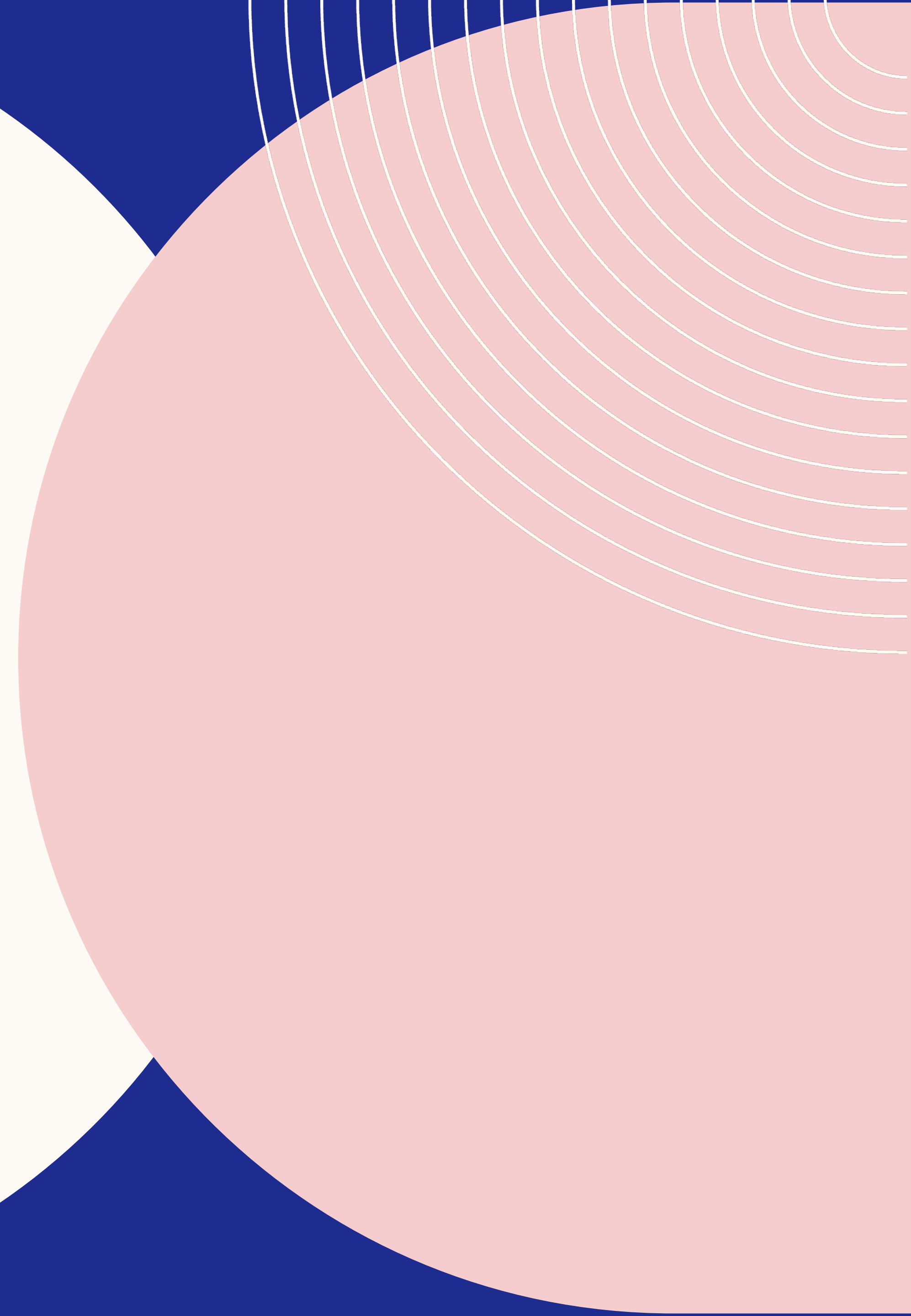
CULTURAL HUMILITY AND AWARENESS

CASRA Core Values
2024

AGENDA AND TOPICS WE WILL DISCUSS

INTRODUCTION AND HISTORY	COMPETENCY VS HUMILITY	SELF-REFLECTION	BIAS AND STIGMA	(BETTER) SERVICES
On impact of mental health treatment when addressing cultural differences	Understanding the difference between the two and how to work towards cultural humility	How self-reflection is integral to cultural humility and the ADDRESSING framework	Unconscious & influential attitudes towards mental health treatment and clients receiving services	Disparities in mental health and healthcare systems and how to improve services provided

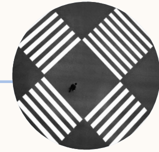
HOW DOES YOUR CULTURE INFLUENCE AND IMPACT YOUR WORK IN THE MENTAL HEALTH FIELD?



DEFINITIONS

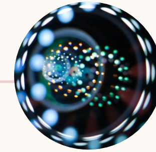
CULTURE

social behavior, institutions, and norms found in human societies, as well as the knowledge, beliefs, laws, customs, and habits of the individuals in these groups



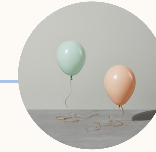
INTERSECTIONALITY

interconnected nature of social categorizations such as race, class, and gender as they apply to a given individual or group



CULTURAL HUMILITY

the use of self-humility, introspection, and co-learning that informs interpersonal relating with an open awareness of diverse cultural identities



CULTURAL AWARENESS

the knowledge, awareness, and acceptance of other cultures and others' cultural identities

CULTURAL COMPETENCY

the use of academic knowledge and trainings to build an *understanding* of diverse cultures with an end-goal of providing more appropriate services

HISTORY

European and Western cultures have historically defined the field of counseling and psychotherapy and practices

Defining “health” / “illness” / “wellness” / “normal” / “impaired” / etc.

Almost always embedded with the cultural context

CULTURAL IMPACTS ON MENTAL HEALTH

-How health and illness are perceived

-Health seeking behavior

-Attitudes of the consumer

-Attitudes of the practitioner

“Culture influences what gets defined as a problem, how [it] is understood, and which solutions…are acceptable.” (Hernandez et al.)

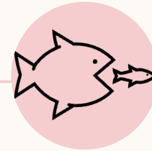
AUTHORS REGINA HECHANOVA AND LYNN WAELDLE SUGGEST THAT THERE ARE FIVE KEY COMPONENTS OF DIVERSE CULTURES THAT HAVE IMPLICATIONS FOR MENTAL HEALTH PROFESSIONALS (CONTEXT OF DISASTER SITUATIONS IN SOUTHEAST ASIA)

EMOTIONAL EXPRESSION

The way emotions are presented and possible reluctance to engage in talking therapy

SHAME

The role of family and a reasoning to avoid treatment

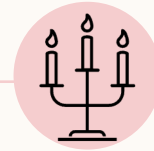


POWER DISTANCE

Power differences in a therapeutic relationship

COLLECTIVISM

a supportive factor to resilience and coping



SPIRITUALITY AND RELIGION

from the point of view of attribution as well as in terms of coping with disease

THE FALLACY OF CULTURAL COMPETENCY

- Sets the unattainable goal that there can be an achieved 'competence' in a culture other than one's own.
- Implies categorical knowledge can be learned about groups of individuals
- Supports the myth that cultures are monolithic.
- Based upon academic knowledge rather than lived experience.
- Believes professionals can be "certified" in culture.

CULTURAL HUMILITY

coined by Melanie Tervalon and Jann Murray-Garcia (1998)

3 major parts:

- Life-long learning and critical self reflection,
- recognize and challenge power disparities,
- institutional accountability

•Learning with and from clients.

•No "end result," encourages lifelong learning with appreciation of the journey of growth and understanding.

•"Even in sameness, there is difference"

•Puts professionals and clients in a mutually beneficial relationship and attempts to diminish damaging power dynamics.

•An awareness of who we are as individuals is central—who we are informs how we see one another

HOW TO START DEVELOPING CULTURAL HUMILITY

An awareness of the self is central to the notion of cultural humility

Awareness may stem from self-reflective questions such as:

- Which parts of my identity am I aware of? Which are most salient?
- Which parts of my identity are privileged and/or marginalized?
- How does my sense of identity shift based on context and settings?
- What are the parts onto which people project? And which parts are received well, by whom?
- What might be my own blind spots and biases?

With this awareness, a provider can ask questions about how they receive the patient:

> Who is this person, and how do I make sense of them? What knowledge and awareness do I have about their culture? What thoughts and feelings emerge from me about them?

CULTURAL PRACTICES COMPARED

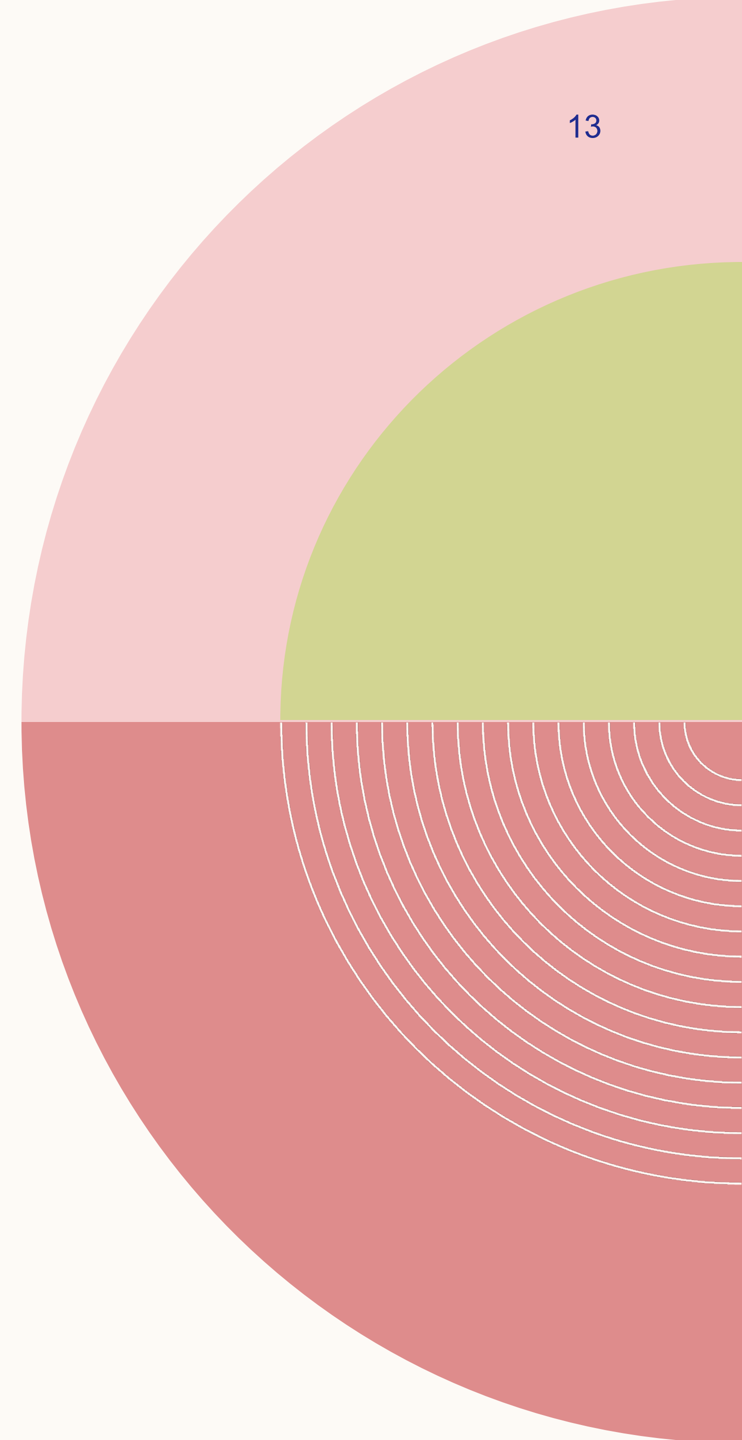
	Cultural competence	Cultural humility
Goals	To build an understanding of minority cultures to better and more appropriately provide services	To encourage personal reflection and growth around culture in order to increase service providers' awareness
Values	• Knowledge • Training	• Introspection • Co-learning
Shortcomings	• Enforces the idea that there can be 'competence' in a culture other than one's own. • Supports the myth that cultures are monolithic. • Based upon academic knowledge rather than lived experience. Believes professionals can be "certified" in culture.	• Challenging for professionals to grasp the idea of learning with and from clients. • No end result, which those in academia and medical fields can struggle with.
Strengths	• Allows for people to strive to obtain a goal. • Promotes skill building.	• Encourages lifelong learning with no end goal but rather an appreciation of the journey of growth and understanding. • Puts professionals and clients in a mutually beneficial relationship and attempts to diminish damaging power dynamics.

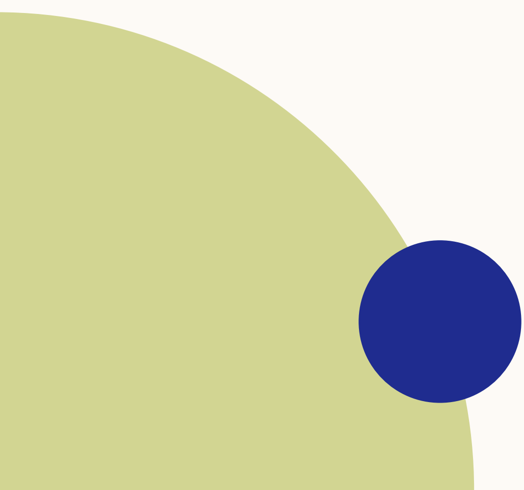
(Wikipedia)

10 minutes

SELF-REFLECTION

How do we practice self-reflection?





PLACING ONESELF USING THE ADDRESSING FRAMEWORK

(Hays, 2008)

CULTURAL INFLUENCES

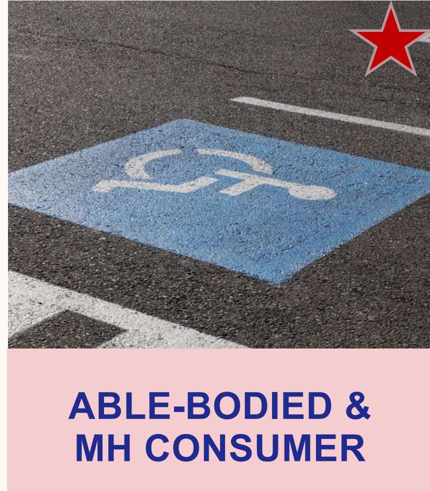
- **A**ge/generational
- **D**evelopmental and other **D**isability
- **R**eligion and spirituality
- **E**thnic and racialized identity
- **S**ocioeconomic status
- **S**exual Orientation
- **I**ndigenous heritage
- **N**ational origin
- **G**ender

MARGINALIZED/ NONPRIVILEGED GROUPS

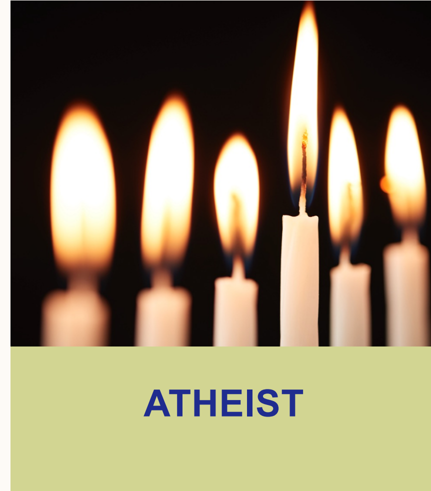
- Children, adolescents, elders
- Those with developmental, physical, sensory, psychiatric, or cognitive disability
- People of Muslim, Jewish, Buddhist, Hindu, and other nonprivileged faiths
- People of African, Black, Asian, PI, South Asian, Latinx, multiracial heritage/identity
- People of lower status by education, income, occupation, rural/urban habitat
- Gay, lesbian, bisexual, pansexual people
- Indigenous/Aboriginal/Native people
- Refugees, immigrants, international students
- Women, Transgender, and Nonbinary people

PLACING ONESELF

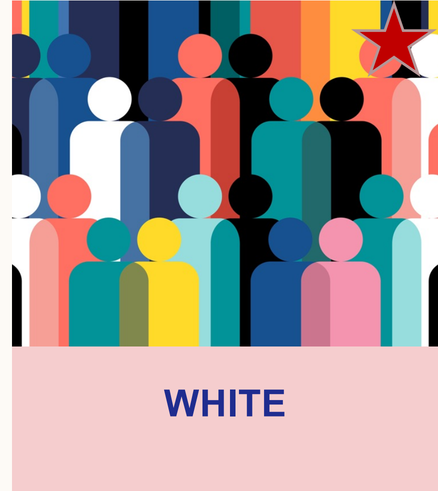
MILLENNIAL (30)



ABLE-BODIED & MH CONSUMER



ATHEIST



WHITE

EMPLOYED & PROVIDER

QUEER

US CITIZEN & NON-INDIGENOUS

CIS-GENDER & FEMALE

PLACING ONESELF USING THE ADDRESSING FRAMEWORK

(Hays, 2008)

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BREAK OUT ROOMS

(15 min)
Note the factors in your identity that are most salient and could carry power and privilege, and those that do not.

Note anything that stood out to you regarding your self-reflection

Diagnosing of Clients

Professional/Patient Models

Access to Services

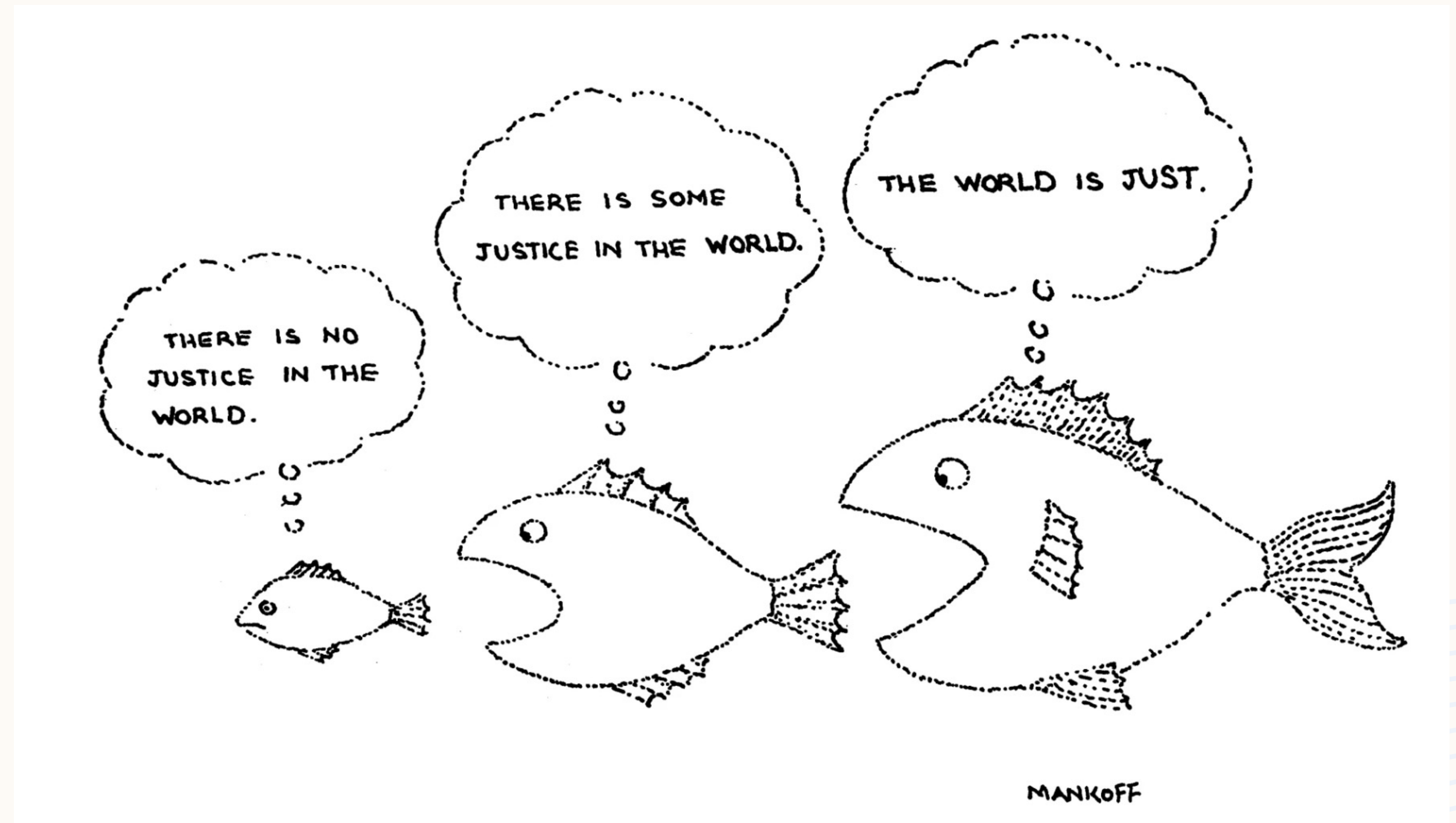
and Cultural Responsiveness
towards Individual Clients

PERSPECTIVE

"[J.B.] Miller points out that dominant groups generally do not like to be reminded of the existence of inequality.

Because rationalizations have been created to justify the social arrangements, it is easy to believe everything is as it should be."

(Tatum, 2001, In reference to Miller,1976).



BIAS

Building self-awareness

Bias is best thought of as a tendency to think, act, or feel in a particular way.
Bias is a natural inclination for or against an idea, object, group, or individual.

2. We're all biased but we don't all belong to dominant cultural groups.
3. Bias + Power = Systems of privilege ('isms).
4. Marginalized members are socialized to be aware of the lines separating those who have privilege from those who do not.
5. Privileged members are socialized to ignore these lines and differences.
6. Privilege separates and cuts Privileged members off from valuable knowledge regarding Marginalized groups.

Hays

By reflecting critically on judgments and being aware of blind spots, individuals can avoid stereotyping and acting on harmful prejudice.

IMPLICIT BIAS

Explicit Bias = Conscious biases
Implicit Bias = Unconscious biases

Everyone holds unconscious beliefs about various social and identity groups

Preconceived notions or assumptions made about certain groups

Unconscious bias and mental health links:

Bias can negatively influence a mental health care provider's willingness to engage in patient-client care, refer treatment, or even adhere to guidelines when serving different groups of people.

SOME IMPLICIT BIASES

DISCRIMINATING AGAINST SOMEONE BECAUSE OF THEIR AGE.

Ageism

THIS BIAS REFERS TO OUR TENDENCY TO GRAVITATE TOWARD PEOPLE SIMILAR TO OURSELVES.

Affinity Bias

JUDGING PEOPLE, PARTICULARLY WOMEN, BASED ON HOW ATTRACTIVE WE THINK THEY ARE.

Beauty Bias

REFERS TO THE TENDENCY TO LOOK FOR OR FAVOR INFORMATION THAT CONFIRMS OUR BELIEFS.

Confirmation Bias

THIS BIAS REFERS TO COMPARING THE PERFORMANCE OF DIFFERENT PEOPLE BECAUSE THEY WERE EXPERIENCED EITHER SIMULTANEOUSLY OR IN CLOSE SUCCESSION

The contrast effect

THIS IS THE TENDENCY TO PREFER ONE GENDER OVER ANOTHER OR ASSUME THAT ONE GENDER IS SUPERIOR OR BETTER AT SOMETHING.

Gender Bias

WHEN YOU JUDGE A PERSON BASED ON THEIR NAME AND PERCEIVED BACKGROUND.

Name Bias

TENDENCY TO PUT SOMEONE ON A PEDESTAL OR THINK MORE HIGHLY OF THEM AFTER LEARNING SOMETHING IMPRESSIVE ABOUT THEM OR PERCEIVING SOMEONE NEGATIVELY AFTER LEARNING SOMETHING NEGATIVE ABOUT THEM.

Halo/Horns Effect

The list goes on…

STIGMA

Stigma exists in individuals and communities and groups from various cultures surrounding mental health concerns.

SELF-STIGMA

Self-stigma leads to negative effects on recovery among people diagnosed with severe mental illnesses.
Effects can include:

- reduced hope
- lower self-esteem
- increased psychiatric symptoms
- difficulties with social relationships
- reduced likelihood of staying with treatment
- more difficulties at work
- Reluctance to seek help or treatment and less likely to stay with treatment
- Social isolation
- The belief that one will never succeed at certain challenges or that they can't improve their situation

- Lack of understanding by family, friends, coworkers, or others
- Fewer opportunities for work, school or social activities or trouble finding housing
- Bullying, physical violence or harassment
- Health insurance that doesn't adequately cover mental health treatment

SOME WAYS TO COMBAT STIGMA

- **Talk openly** (about mental health)
- **Educate yourself and others**
- **Be conscious of language**
- **Encourage equality**
- **Show compassion**
- **Be honest about treatment** (normalize)
- **Let the media know**
- **Choose empowerment** (resilience and survivorship over shame)

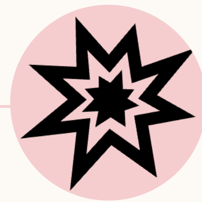
10 minutes

- A person focusing on their individual experience, rather than society at large

CULTURAL FAUX PAS

WHAT THEY ARE

- **doing something offensive to another person's culture on accident.**



WHAT ARE THE IMPACTS

- Distrust or mistrust of providers and the mental health system that may be seen as closed minded or not taking the client's experience into account.
- May cause an issue in rapport building and confidence in the Tx process

HOW WE RECOVER

- Breathe!
- Accept Responsibility
- Be open to feedback
- Be self-reflective
- Learn from your experience
- Move forward—don't dwell

MICRO AGGRESSIONS

RACIAL MICRO-AGGRESSIONS

"Where are you really from?"

implies that a person doesn't look like they belong in the country or area

GENDER MICRO-AGGRESSIONS

Referring to assertive female professionals as being "bossy" or "emotional,"

while male counterparts exhibiting the same behaviors are viewed as "confident" or "strong leaders."

LGBTQIA+ MICRO-AGGRESSIONS

•**Using incorrect pronouns intentionally or repeatedly after being corrected**

invalidates the person's gender identity.

•**Assuming everyone is heterosexual**

asking a woman if she has a boyfriend/husband or a man if he has a girlfriend/wife

DISABILITY MICRO-AGGRESSIONS

•**Speaking to a person with a disability in a condescending tone,** as if they were children,

•undermines their competence and autonomy.

•**"You're so inspirational!"**

can imply that it is surprising a person with a disability can manage x, y, z, task

Micro-aggressions are harmful because they perpetuate stereotypes and reinforce societal inequalities.

Break Out Room:

HOW DO/CAN CULTURAL DIFFERENCES LEAD TO HEALTHCARE DISPARITIES

(15 min)
How have you seen or heard of healthcare disparities in your field, practices, or organizations?

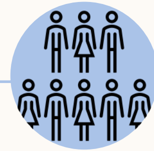
HEALTHCARE DISPARITIES

- Quality of Care
- Unwarranted judgments on a cultural basis (perceived single experience over individual care) that lead to bias
- Providers' inappropriate expectations lead to inappropriate decisions and actions.
- Biased views can result in action or a failure to act
- Access to services and confidence in services

HOW TO PROVIDE BETTER SERVICES

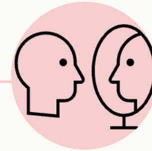
EDUCATE

Yourself and others on the impacts of culture on mental health services



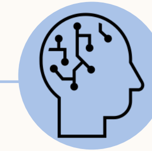
COLLABORATE

With varying perspectives and understandings. Be Client-led



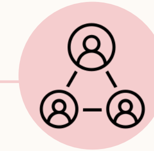
LOOK INWARD

Be self-reflective and accountable to mistakes



BUILD AWARENESS

Learn and grow from your experiences and listen to the experiences of others for better awareness and responsiveness



RESOURCES

Admit you don't know things when you don't, and seek resources that could improve overall care

DEVELOPING A CULTURE OF PARTNERSHIP IN TREATMENT

Client input is crucial

Building **relationships** between provider/care team and clients/communities.

CONCLUSION

When taking a culturally responsive and recovery-based approach, the client and the needs expressed by the client are invaluable

The Client will decide how to engage with treatment.

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