Practice Parameter for Cultural Competence in Child and Adolescent Psychiatric Practice

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The United States faces a rapidly changing demographic and cultural landscape, with its population becoming increasingly multiracial and multicultural. In consequence, cultural and racial factors relating to mental illness and emotional disturbances deserve closer attention and consideration. This Practice Parameter outlines clinical applications of the principle of cultural competence that will enable child and adolescent mental health clinicians to better serve diverse children, adolescents, and their families. J. Am. Acad. Child Adolesc. Psychiatry, 2013;52(10):1101–1115. **Key Words:** culture, ethnicity, race, cultural competence, acculturation

The rapidly changing demographics of the United States are largely the result of 3 major factors: progressive aging and low birth rate of the European-origin population, younger mean ages and increasing birth rates in non-European minority groups, and a significant increase in immigration from non-European countries, especially from Latin America, Asia, and Africa. By 2050, European Americans will no longer constitute the majority, and this will happen by 2030 among children younger than 18 years and is already true among children younger than 8 years.[1] The process of evaluating and treating culturally diverse children and youth and their families can be complex and requires special expertise and unique approaches. Thus, this parameter can be useful for clinicians and, ultimately, for the children and families they serve. Principles in this parameter apply to culturally diverse children and youth younger than 18 years.

METHODOLOGY

In PubMed, the Medical Subject Heading (MeSH) terms *culture, Hispanic, Latino, African American, Asian American, American Indian, child psychiatry, child psychology, adolescent psychiatry, adolescent psychology,* and *United States* were searched. The initial search yielded 2,970 results. Then, the results were limited to *English, human, all child (0 to 18 years),* and *1990 through December 2011.* Additional limits included *classical article, clinical trial, comparative study, controlled clinical trial, evaluation studies, guideline, historical article, meta-analysis, practice guideline, multicenter study, randomized controlled trial, review, twin study,* and *validation studies.* The refined PubMed search yielded 2,268 articles.

In the PsycINFO database subject headings (focused), the keywords *culture, Latino, Hispanic, African American, Asian American, American Indian,* and *mental health* were searched. The initial search returned 40,167 articles and then was limited to *English,* articles in the United States, *childhood: birth to age 12 yrs, adolescence: age 13-17 yrs, peer reviewed journal,* and *1990 through December 2011.* The refined PsycINFO search yielded 2,240 articles.

In the *Cochrane Database of Systematic Reviews,* keywords of culture and mental health were searched without additional limits. The Cochrane search yielded 80 articles. An additional 953 articles were retrieved from the CINAHL database, after excluding Medline articles, by searching *culture, Latino, Hispanic, African American, Asian American, American Indian, mental health,* and *United States* and limiting to *childhood and adolescence, peer-reviewed articles, English language,* and *1990 through December 2011.*

A total of 5,461 articles were identified. After removing duplicate references, the resulting yield from the comprehensive search was 4,391 articles. The titles and abstracts of all articles were reviewed. Studies were selected for full-text review based on their place in the hierarchy of evidence (e.g., randomized controlled trials), quality of individual studies, and generalizability to clinical practice. The search was augmented by a review of articles nominated by expert reviewers and further search of article reference lists and relevant textbook chapters. A total of 163 articles were selected for full-text examination. Principles were identified from the consensus of the American Academy of Child and Adolescent Psychiatry (AACAP) Diversity and Culture Committee and informed by the literature review articles and the *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Populations*.[2]

DEFINITIONS

- Culture: Integrated pattern of human behaviors including thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social nature.
- Cultural competence: Set of congruent behaviors, attitudes, and policies found in a system, agency, or professionals that enables them to work effectively in a context of cultural difference.[3]
- Acculturation: Process of change in the cultures of 2 or more groups of individuals from different cultures, resulting from their continuous first-hand contact.[4]
- Race: Social classification system based on a set of external physical characteristics that are socially significant within a specific culture.
- Ethnicity: Common historical or geographic heritage shared by a group of people.
- Immigrant: Someone who intends to reside permanently in a new land.

HISTORICAL OVERVIEW

The recent demographic changes in the United States are highly significant for child mental health services. First, the acceptability and use of mental health services are governed strongly by cultural attitudes, beliefs, and practices. Second, the current science base of psychiatric diagnosis and treatment is derived from research primarily involving European-origin populations, so its validity for these emerging populations is not fully established. Third, minority populations face many increasing challenges around mental illness, including different sources of stressors, changing patterns of psychopathology, less access to services and evidence-based treatments, and greater burdens of morbidity and possibly mortality than Euro-Americans. For example, Latino and African American youth have significantly higher rates of suicidal ideation and attempts compared with Euro-Americans.[5]

The current health care system does not effectively address the needs of culturally diverse populations. The recognition of racial and ethnic disparities in general health care has led to increasing recognition of similar disparities in mental health care.[6,7] Obvious examples of mental health disparities are the child welfare and juvenile justice systems. More than 50% of children and youth in the child welfare system are African American, Latino, and American Indian children, and more than 65% of the children and youth in the juvenile justice system are African American and Latino.[1,8] These systems also serve disproportionate numbers of mentally ill children, and their racial ethnic disparities are associated with a lack of early access to mental health services to prevent such outcomes. At the same time, in response to these mounting challenges, *cultural competence* became one of the core principles of the children's community-based systems-of-care movement.[3]

PRINCIPLES

Principle 1. Clinicians should identify and address barriers (economic, geographic, insurance, cultural beliefs, stigma, etc.) that may prevent culturally diverse children and their families from obtaining mental health services.

Non-Hispanic white families are twice as likely as minority families to seek mental health treatment for their children[9-11] despite evidence suggesting the prevalence of psychiatric disorders in children does not appear to vary greatly by race or ethnicity.[12] When minorities seek treatment, they may not remain engaged in outpatient services or use as many service units.[10,11] Multiple systemic and logistical barriers that interfere with timely access to services are disproportionately experienced by racially/ethnically diverse families. These include financial needs, location of services and transportation, lack of adequate insurance, poorly understood bureaucratic

procedures, and lack of linguistic support. Even when minority children and families receive services, these are often interrupted prematurely by these barriers.[13]

Although many traditional cultural values and beliefs are a source of strength and support for diverse children and families, some can act as barriers to mental health services. For example, a survey of Latinos found that factors such as perceptions of mental illness (including stigma and beliefs about causality), fatalism, spirituality, "familism" (in which the family is considered the primary unit of identification and allegiance[3] and leads to keeping problems within the family), cultural commitment (e.g., to using only culturally sanctioned helping approaches), and language proficiency[14] affect their treatment. Abe-Kim et al.[15] found that rates of mental health–related service use, subjective satisfaction, and perceived helpfulness of services varied by birthplace and generation; United States–born Asian Americans used services at higher rates than their immigrant counterparts; and third-generation or later individuals had the highest (62.6%) rates of service use in the previous year.

Stigma can be a powerful barrier to timely access to treatment. In many cultures, mental illness has major negative connotations, leading to the fear of double discrimination (as a result of being culturally different and perceived as "crazy"), which prevents minority families from accessing services. These perceptions can then become self-reinforcing when emergency services are needed owing to the traumatic impact of suddenly receiving a more restrictive level of care and/or their involuntary nature.[16] Families may mistrust mental health service agencies given their histories of discrimination and disregard for cultural needs.[17] Culturally diverse families are more vulnerable to perceived or actual power differentials in their encounters with health care professionals.

Diverse families should be educated to improve their understanding of diagnosis and treatment, empower decision making, expose myths, and improve treatment outcomes.[2] Clinicians should address the realities and perceptions of power differentials that may interfere with therapeutic relationships.[8]

It is not uncommon for minority children and adolescents to engage in mental health treatment for troubling behaviors identified by the school or the court, rather than by their parents.[13] One explanation is that minority families tend to have a higher threshold for disruptive behaviors and to not seek professional intervention until the situation becomes unmanageable.[18] Yeh et al.[19] reported that children and adolescents of ethnic and racial minorities are referred for mental health treatment from involuntary sources such as the child welfare and juvenile justice systems more often than their white counterparts, with rates of self-referral to community services that are lower than those for whites. Although socioeconomic class can contribute to these disparities, they affect minority youth at higher rates than white youth even when controlling for socioeconomic status.

Principle 2. Clinicians should conduct the evaluation in the language in which the child and family are proficient.

Language-based communication is critical in obtaining accurate clinical information and establishing a therapeutic alliance. Many immigrants, however, are not fluent in English and thus may be unable to fully participate in the clinical process. In these situations, translation and interpretation are critical to effective care. Limited English proficiency is a significant barrier to accessing mental health services for adults and children from different ethnic origins, resulting in significantly lower utilization of mental health services.[11,14,20] Lack of appropriate linguistic ability or interpreter support has been associated with misdiagnosis and adverse clinical outcomes.[21,22] In these cases, clinicians should obtain linguistic support through qualified interpreters or possess demonstrable proficiency in the target language. Unfortunately, translation and interpretation are often considered menial or informal tasks in the clinical process, as reflected by using untrained interpreters or translators without regard to impact on family relations, family members, siblings, or the child.[2] Language brokering, the common practice of having children act as interpreters between parents and medical and school authorities, should be avoided, particularly when the patient is the language broker. An association has been identified between high language-brokering contexts and higher levels of family stress, lower parenting effectiveness, poorer adjustment in academic functioning, higher Child Behavior Checklist internalizing scores, and substance use in adolescents.[23] Telephonic interpretation services enable 24-hour access and a wide range of available languages but are not ideal owing to their lack of ability to

convey nonverbal communication. Interpreters should have proper training in the skill of interpretation and the content area being discussed. They should serve as integral members of the clinical team, serve as cultural consultants when they have understanding of the family's culture, and interpret all verbal, nonverbal, and implicit communications from the child and family rather than provide summaries.[24] If live translation services are not available, clinicians may have to use alternatives (telephonic interpreter services, individuals with dual-language abilities, or someone the family or child identifies), but efforts should be made to obtain the consent of the individuals using written or nonverbal means. Any educational materials and rating or diagnostic instruments should be translated to the language of the family member or child, and their reliability and validity in the target cultural group should be established using well-accepted reverse translation and psychometric methodologies. In the event materials or instruments have not been formally translated or validated, practitioners should access translation services from trained professionals or from bilingual child mental health professionals. Clinicians should be cautious about clinical interpretations based on diagnostic instruments not properly translated or validated with the population in question.[2,24]

Principle 3. Clinicians should understand the impact of dual-language competence on the child's adaptation and functioning.

An estimated 20% of American children 18 years and younger grow up exposed to 2 languages. Learners of English as a "second language" (defined as any language learned after 3 years of age, which is the end of the critical period for rapid language acquisition) constitute the majority of dual-language children in America. After English, the most common home language in the United States is Spanish.[25,26] Grammatical and other language errors made by a child learning a second language (or a second English dialect, such as standard American English for a speaker of Black English) should not be confused with the grammatical or lexical abnormalities of language disorders. In contrast, deficits associated with psychiatric and language disorders (such as auditory-verbal working memory deficits) may slow the acquisition of a second language. Specialized consultation and assessment over time by a speech/language pathologist with expertise in dual-language

children may be necessary to differentiate normal from disordered language acquisition.[26]

There is evidence that maintaining the first (home) language is important in accessing family and community protective factors and other benefits. Despite this evidence, there has been a poorly substantiated practice of recommending to parents that they discontinue speaking the home language to a child who is facing language, cognitive, or other delays. This practice has little or no empirical support, and the limited research conducted in this area suggests that children with language impairment can be healthily exposed to and learn 2 languages with no significant detrimental effects.[26] Although it may be true that certain children with linguistic or other deficits may become overwhelmed by the additional cognitive and linguistic demands of dual-language learning, recommendations to discontinue learning the home language may have potentially serious consequences and should not be made lightly. Rather, such decisions should ideally involve full assessment by a speech/language pathologist with appropriate expertise, consultation with the parents and others who know the child well, and an informed decision process by the parents with consideration of the family's plans for the future.[26] For example, a child whose family speaks only a minority language may need to maintain and learn that language.

Sudden language immersion may be stressful, depending on the child's temperament and availability of supports. Children who are suddenly immersed in a second language environment with no knowledge of the language may go through a normal "nonverbal period." This should not be confused with selective mutism, which has a higher prevalence among immigrant dual-language children. Thus, it is important that clinicians be familiar with features that differentiate the normal nonverbal period from selective mutism, which typically lasts much longer.[27]

Principle 4. Clinicians should be cognizant that cultural biases might interfere with their clinical judgment and work toward addressing these biases.

Adult and pediatric psychiatry literatures provide evidence for cultural and racial disparities in diagnostic assessment, treatment measures, and quality of received health care.[8,10,28] Stereotyping, biases, and uncertainties in health care providers can lead to unequal treatment.[6,29]

When the patient's presentation or diagnosis is unclear, physicians may inadvertently over-rely on behavioral or clinical stereotypes of specific groups at the expense of focusing on the patient's unique experience, clinical presentation, or sociocultural context.

Stereotyping is defined as the process by which people use social categories (e.g., race, sex) to acquire, process, and retrieve information about others. Because stereotyping can be a subtle cognitive phenomenon resulting from virtually universal social categorization processes, it also occurs, often unconsciously, among people who strongly endorse egalitarian principles and truly believe that they are not prejudiced.[30] In the United States, there is considerable empirical evidence that well-meaning people who are not overtly biased and do not believe they are prejudiced typically demonstrate implicit (i.e., unconscious) negative racial attitudes and stereotypes.[31]

Prejudice is defined in psychology as an unjustified negative attitude based on a person's group membership.[31] Although in general medicine evidence exists that provider biases adversely affect quality of care for minority patients,[6] this has not been extensively studied in mental health. Research does suggest that behavioral and general health care providers' diagnostic and treatment decisions and their feelings about patients are influenced by race or ethnicity. For example, mental health professionals subliminally "primed" with African American stereotype-laden words were more likely to evaluate the same hypothetical patient (whose race was not identified) more negatively than when primed with neutral words.[32]

Principle 5. Clinicians should apply knowledge of cultural differences in developmental progression, idiomatic expressions of distress, and symptomatic presentation for different disorders to the clinical formulation and diagnosis.

Motor, language, cognitive, and social development appear to differ across cultures. These differences may result from developmental expectations consistent with differentiated cultural value systems. Such differences, seen out of cultural context, could lead to the misidentification of pathology or misdiagnosis of mental disorders.[24,33] Expressions for psychological or emotional distress also differ across cultures. Idioms of distress are linguistic or somatic patterns of experiencing and expressing illness, affliction,

or general stress.[34] Idioms of distress do not generally correspond to diagnostic categories. They can at times be an alternative means of expression for disorders recognized by Western psychiatry, such as depression or anxiety disorders. However, they can just as easily be expressions of psychological distress unique to a given culture or even common normative expressions of stress. More complex expressions of illness or distress are termed *cultural syndromes*.[34] Idioms of distress and cultural syndromes can often be mistaken for more serious psychopathology, although they are often normal variants of expression of distress. For example, *ataques de nervios* (a reaction combining anxiety, agitation, and dissociation common among Latinos of Caribbean origin) can be confused with a psychotic reaction, whereas *falling out* (an expression of emotional stress among Afro-Caribbeans that includes sudden acute paralysis and dissociation) can be confused with catatonia.

Common patterns of symptomatology displayed by children from diverse populations can differ significantly from those in Euro-Americans due in part to the influence of their culture. For example, in minority youth, somatization and anger are frequently associated with depression and anxiety, and psychosis is often overdiagnosed.[28,35] Emotional reactivity during depression is greater in Asian-origin individuals than in whites.[36]

In the evaluation of children from less assimilated families, it is critical to recognize cultural manifestations of distress or illness, such as cultural syndromes. Accurate assessment can prevent misdiagnosis and erroneous treatment. It is important to seek consultation from a colleague with cultural expertise on the cultural context and the significance of particular idiomatic expressions or symptoms that may be culturally influenced.[2]

The *DSM* Outline for Cultural Formulation has provided a useful framework for assessing sociocultural aspects of the patient's mental health and relating these to the clinical formulation.[37,38] The *DSM-5* provides a revised version[39] that calls for systematic assessment of 5 distinct categories: *cultural identity of the individual*, consisting of the individual's racial, ethnic, or cultural reference groups and other relevant aspects of identity, such as degree of involvement with the culture of origin versus host culture, religion, socioeconomic background, place of origin, migrant background, and sexual orientation; *cultural*

conceptualization of illness, including the influence of cultural beliefs on the individual's experience, conceptualization, and expression of symptoms or problems; *psychosocial stressors and cultural features of vulnerability and resilience,* including key stressors and supports in the individual's socio-cultural environment (such as religion, family, and social supports); *cultural features of the relationship between the individual and the clinician,* such as dynamics of differences based on cultural, socioeconomic, language, and social status that may cause differences in communication and influence diagnosis and treatment; and *overall cultural assessment* summarizing the implications of these aspects for diagnosis, plan of care, and other clinically relevant issues.

The *DSM-5* also includes the Cultural Formulation Interview (CFI),[39] a 16-item semistructured interview to obtain information about the impact of culture on clinical presentation and care, with suggested questions to inquire about different domains. The CFI contains 4 assessment domains: cultural definition of the problem; cultural perceptions of cause, context, and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking. The CFI also includes Supplementary Modules as adjuncts to the core CFI that provide more in-depth assessment of various areas. The CFI was field tested for diagnostic utility among clinicians and acceptability among patients as part of the *DSM* field trials, although the trials did not include children and youth.

An important reference for cultural differences in developmental progression, expressions of distress, and symptomatic presentation by gay, lesbian, and transgendered youth, and how these affect their assessment and treatment can be found in the AACAP Practice Parameter for gay, lesbian, and transgendered youth.[40]

Principle 6. Clinicians should assess for a history of immigration-related loss or trauma and community trauma (violence, abuse) in the child and family and address these concerns in treatment.

Migration has risks and stressors unique to immigrants. These can be divided into premigration stress, such as exposure to violence, persecution, and torture in the country of origin; migration stress, including the disruption and separation of families, traumatic journeys, detention in refugee camps, and various forms of victimization, such as abuse by smugglers; and postmigration and acculturation stress, resulting from low levels of education and job skills,[41] living in high-risk neighborhoods, with high exposure to crime and violence, and over-crowded, poor-quality inner-city schools.[42] In addition, immigrant children and their families often face the stressors of prejudice and discrimination against immigrants and those experienced by nonimmigrant minorities, especially if racially different from the majority culture,[43-45] which may lead to poor academic functioning, low self-esteem, depression, and suicide.[44] Some minority youth adopt a position of defiance against the dominant culture by joining gangs.[46] As a result of these stressors, second-generation children of immigrants are generally at increased risk for mental health problems, including anxiety, depression, substance abuse, and posttraumatic stress disorder (PTSD).[47] The stresses of immigration on the family also can result in domestic violence and criminal activity.[48] Factors such as parental emotional well-being and peer relationships can mitigate or aggravate these problems.[44]

Immigration to the United States can lead to complex patterns of family fragmentation and reunification. To become established, parents may immigrate before their children, leaving them with relatives in the country of origin. Children are often brought to the United States years later with hopes of offering them a better education and future. Children are often torn away from grandparents and other extended family members who have become their primary caregivers, often with little recognition of the mourning process involved. Parents can become dismayed and disappointed with the unhappiness, even rejection, their estranged children may demonstrate toward them.[49] Children who have experienced such separations or losses have a higher risk for later developing depression, conduct disorder, and substance abuse disorders compared to other immigrant children.[44,49] Adolescent victims of war and genocide have elevated rates of conduct disorder, aggressive and sexual acting-out behaviors, substance abuse, depression, and PTSD.[50,51] Those exposed to traumatic crossings and confinement in refugee camps experienced silent symptoms of PTSD, which often went unnoticed by teachers.[43,50,51] Treatment of immigrant and refugee children and inner-city minority children must address traumatic exposure from these various sources, use evidence-based interventions that address the

impact of trauma in the child and family, and provide for community support.[51]

Principle 7. Clinicians should evaluate and address in treatment the acculturation level and presence of acculturation stress and intergenerational acculturation family conflict in diverse children and families.

Acculturation directly affects the developmental task of identity, just as racial/ethnic identity constitutes a significant aspect of psychological identity. Peers and family members serve as "mirrors" against which the self is reflected.[4,44] For racially/ethnically diverse children and youth, this mirroring comes from 2 sources: the traditional cultural environment of the home and the mainstream cultural environment of peers, school, and the broader community, which can result in conflicting images. Diverse children and youth often face significant pressures to assimilate into mainstream society through media images and implicit threats of social and economic marginalization. In the process of acculturation, research supports that the best adaptational outcomes for youth are associated with the development of a *bicultural identity,* in which the immigrant youth remain rooted in their culture of origin (often mediated by learning the home language) but have the necessary knowledge and interpersonal skills to successfully navigate mainstream culture (i.e., a hyphenated identity).[4,44] However, immigrant children and families face other potential outcomes: *marginalization,* with separation from the 2 cultures and some degree of ethnic identity diffusion; *assimilation,* in which the culture of origin is rejected and the host culture is largely adopted, with the loss of language and customs of origin; *separation,* in which the host culture is rejected and there is a strong adherence to the traditional culture and language, often remaining bound to the "ethnic enclave"; and *negative identification,* a form of marginalization in which the youth is openly hostile to the 2 cultures and adopts values and practices antithetical to both (e.g., adoption of gang culture).[4,52]

Acculturation stress is the distress and internal conflict resulting from adaptation to a new host culture, including internal cultural value conflicts and external pressures to assimilate, and facing the host society's hostility in the form of racism and discrimination. It also can result from the loss of protective aspects of the traditional culture that help with developmental stresses (e.g., religious prohibition against suicide) while not yet adopting those from the host culture.[4] Acculturation stress can increase risk for psychopathology including substance abuse, depression, anxiety, suicidality, conduct disturbance, and PTSD.[4,53] It also can aggravate pre-existing conditions. For example, the rates of PTSD decreased more in Bosnian than in Southeast Asian immigrant youth who were victims of ethnic cleansing 1 year after immigration. Becker *et al.*[54] speculated that fewer cultural differences between the country of origin and the host country accounted for the better adaptation of Bosnian refugees to the United States. Some studies have found associations between a stronger ethnic identity and lower acculturative stress, better academic performance, better psychological adaptation, and fewer externalizing and internalizing symptoms, but greater awareness of discrimination. Parental stress and family separations can adversely affect acculturative stress, whereas positive family relations can ameliorate it.[4,44]

Many immigrant families are headed by parents with traditional cultural beliefs, who are experiencing the process of acculturation themselves but without their children's cognitive, linguistic, or emotional flexibility. Differences in acculturation between parents and children can lead to intergenerational acculturation conflict, which may result in psychological distress. Such acculturation discrepancies are most prominent during adolescence. One factor that may contribute to acculturation conflicts is the assumption of a parentified role by a more assimilated immigrant child as a means of assisting their less assimilated parents to navigate the new cultural milieu of language, rules, and norms. Although parentification can be adaptive, it can represent an inversion in family roles and authority if maintained over time and contribute to heightened intergenerational conflict when parents attempt to assert their authority.[44,55]

Differential acculturation between immigrant parents and their children leads to incongruence of values and expectations, resulting in intergenerational conflict and distancing. In some Asian American families, differential acculturation is a predictor of negative mental health consequences for youth, such as school difficulties, gang involvement, depression, and suicidality. In Hispanic families, orientation to mainstream American culture, when coupled with the retention of Hispanic cultural practices and heritage, is associated with positive adjustment outcomes

in youth, such as the absence of conduct disorders and substance abuse. Increased parental involvement, positive parenting, promoting biculturalism in Hispanic adolescents and their families, and reframing intergenerational difficulties as culturally based disagreements have been efficacious in improving family functioning and adolescent behavior problems.[55-57]

Acculturation stress, intergenerational acculturation conflict, and interventions designed to address them should be routine in the assessment and treatment of children of immigrants or minority families. Interventions aimed at enhancing minority adolescents' mental health should focus on the intergenerational relationship, because it is a predictor of the youths' outcome. Family-based intervention, where intergenerational and intercultural conflict is explored and the value of communication within cultural expectations is underscored, is effective when working with adolescents.[55,56]

Principle 8. Clinicians should make special efforts to include family members and key members of traditional extended families, such as grandparents or other elders, in assessment, treatment planning, and treatment.

In collectivist cultures, in which people view themselves primarily as members of groups and usually consider the needs of the group over the needs of individuals, extended family involvement may be the only acceptable model of addressing emotional and mental health problems. In contrast, in individualistic cultures, these problems are addressed by the individual or immediate relatives. Therapeutic engagement of diverse families may call for strategies not used in individualistic cultures. Involvement of extended family members and non-blood relatives with an equivalent emotional bond (i.e., "fictive kin") is important in obtaining necessary collateral input for appropriate diagnosis, subsequent treatment recommendations, and treatment adherence.[58] Although clearly beneficial, this extended involvement may raise challenging issues of confidentiality. Confidentiality should be maintained in such a manner that it does not interfere with communication and collaboration. Clinicians should explain the importance of confidentiality in psychotherapy to the family, so they are not perceived as "driving a wedge" between the child and the family or used by the patient to resist dealing with family issues. However, family conflict often predicts the use of mental health services for diverse patients, so it is

important that clinicians ascertain whom the patient considers family and determine if they are a source of stress or support.[59]

The mental health literature has explored the potential impact of culture on boundary-keeping practices (i.e., the maintenance of parameters that individuals or societies use to define interpersonal and professional boundaries). People from collectivist backgrounds view concepts that define such boundaries, such as time, confidentiality, dual relationships, and self-disclosure, differently than those from individualistic cultures. These differences can affect the therapeutic process.[60] It is recommended that clinicians carefully negotiate boundaries and treatment parameters with culturally diverse patients and families.[61] During negotiation, the providers should respect culturally established means of communication and family role functioning, but also foster family flexibility in dealing with their bicultural offspring around such issues. This process establishes a collaborative process involving the mental health provider and the family. Savin and Martinez[61] recommended a "graded-risk model" to address boundary issues when treating culturally diverse families. They encouraged clinicians to evaluate potential crossings of professional or interpersonal boundaries, consider potential harm/benefit to the patient/professional relationship, and identify the presence/absence of exploitative or coercive components and professional intent and aspirations, all within the context of the boundary crossing. By using this process model, clinicians can analyze whether a boundary crossing may be harmful or beneficial for treatment.

Accurate, valid consent forms translated into the patient's and family's primary languages and interpreter services are essential (see Principle 2). It may be important to allow the family extra time to consult traditional and family decision makers in their consent process. These decision makers have major influence in the family consent process. Actively avoiding their input can result in significant problems with treatment adherence. An overly paternalistic style on the clinician's part may lead a patient to not return or politely agree to the plan but then not adhere. The use of family psychoeducation is critical to addressing questions and culturally based myths and misconceptions about psychiatric medications, including the rationale for their use, mechanism of action, and benefits versus risks for the child.[2,62] Diverse families often have a

background of limited treatment options and decision-making opportunities. Thus, it is especially important to assist them in developing knowledge and skills to address their child's mental illness, questioning perceived authority, and exercising their rights for second opinions or alternative treatment resources.[17,44]

Principle 9. Clinicians should evaluate and incorporate cultural strengths (including values, beliefs, and attitudes) in their treatment interventions to enhance the child's and family's participation in treatment and its effectiveness.

Clinicians should assume a posture of genuine cultural curiosity in learning about the family's traditional cultural beliefs/values. A culturally competent approach promotes the incorporation of beliefs, values, attitudes, and cultural rituals and practices within mental health treatment, using psychoeducational approaches to bridge traditional understanding of illness and its treatment, with Western conceptualizations and its medical/scientific model.[3,63] The process of participatory or shared decision making, where cultural aspects are integrated into the implementation of evidence-based practice, is crucial to enhance culturally competent care that ensures treatment engagement.[64] Many culturally competent psychotherapeutic approaches and interventions have been developed, including storytelling and cultural themes,[65,66] symbolic rites of passage,[67,68] and matching therapists according to their racial/ethnic background.

Culturally adapted treatment modalities may have some improved effectiveness compared with standard interventions, although the evidence is mixed. Two studies using a correlational approach indicated that ethnic match between client and therapist was associated with positive outcomes after youth- and family-based treatment.[69,70] A meta-analysis of 76 studies evaluating the benefit of culturally adapted mental health interventions found a moderate benefit for culturally adapted interventions.[71] However, another systematic literature review that included a smaller meta-analysis of psychotherapy effects as well as a comparative analysis of aggregate size data of culturally modified psychotherapies found differences in effect sizes to be moderate to not significant.[72]

Diverse cultural groups' explanatory models for mental health and illness can vary, invoking spiritual, supernatural, sociologic, and interpersonal explanatory models. Such explanatory models often lead families to seek help for their children's problems from a spiritual healer, church elder, community leader, or relative, rather than from mental health professionals. Reasons for such preferences include greater acceptability of the healer's explanatory model of illness, greater family support, less stigma for seeking services, and perceived greater rapidity and effectiveness. This preference is seen particularly among first-generation immigrants and refugees, including Latinos, Asian-origin, American Indian, and some European-origin groups.[13]

Clinicians should consider consulting and collaborating with traditional healers (e.g., *curanderos, santeros,* or shamans) and including rituals and ceremonies in psychotherapy with children from more traditional backgrounds. Collaboration with indigenous traditional healers can ameliorate cultural loyalty conflicts within families and children and improve access to care in populations unfamiliar with or even mistrusting of the medical/psychiatric model. This is typically feasible when traditional healing methods complement or enhance (and do not directly conflict with) the effectiveness of Western psychotherapeutic and pharmacologic interventions. Traditional healers are often reticent to identify themselves as collaborating with Western-trained clinicians. However, mutual respect and education in exchanging information and perspectives can foster collaboration.[13]

Principle 10. Clinicians should treat culturally diverse children and their families in familiar settings within their communities whenever possible.

Diverse children and families often prefer ethnically specific community clinics or clinics located within schools or ethnic neighborhoods. For example, a study of referral patterns in 4 Asian American groups demonstrated a clear preference for ethnic-specific mental health services.[73] School-based services are also generally well accepted and highly effective. School-based disaster mental health services after Hurricane Katrina that were culturally adapted and evidence based were effective at reaching minority youth who otherwise might have not gained from these treatments.[74] Similar success was identified in the Cognitive Behavioral Intervention for Trauma in Schools program in diverse ethnic populations within inner-city Los Angeles.[75]

Clinicians should favor home- or community-based alternatives to hospitalization for minority children owing to the integral nature of community and family to their identity and emotional supports. Any out-of-home placement or hospitalization should ideally be accomplished with family and youth cooperation. The principles of treatment in the least restrictive environment are especially important given how some treatments may remove youth from their community, extended family, and traditional cultural supports.[24,76] Involuntary hospitalization should be avoided because it tends to re-exacerbate past traumas, contribute to new ones, and reawaken historic mistrust of the mental health system.[17] Psychiatrically hospitalized African American youth have a significantly greater tendency to be admitted involuntarily, which enhances such fears and mistrust.[28]

The cultural competence model[3] and the principles of community systems of care[76] promote the use of community resources and cultural strengths to facilitate effective interventions with diverse children and youth, reinforcing adaptive cultural values and beliefs. Systems-of-care programs have some demonstrated effectiveness in improving access to care and improving outcomes for diverse children and youth. A meta-analysis of services utilization data versus home community composition for the federal Comprehensive Children's Mental Health Initiative communities[77] found that the program successfully reaches disadvantaged and minority youth and can bring substantial infrastructure to address youth mental health disparities. Systems of care communities serving Latino youth also have demonstrated equivalent clinical and functional outcomes as for white youth.[78]

Principle 11. Clinicians should support parents to develop appropriate behavioral management skills consonant with their cultural values and beliefs.

Culturally diverse parents tend to accept and adhere more to behavioral management skills when these are consonant with their culture. For example, a randomized test of a culturally adapted parent management intervention with Spanish-speaking Latino parents of middle school–aged youth at risk for disruptive behavior disorders, with half in the culturally adapted program and half in the control condition, showed that parents in the culturally adapted program reported higher levels of satisfaction and better outcomes in parenting skills and youth externalizing behaviors. Attendance was high, with 70% of families attending at least 80% of sessions.[79] Kumpfer et al.[80] showed that recruitment and retention was 41% higher in culturally adapted family intervention programs compared with nonadapted versions.

Clinicians should advise families about parenting approaches that may be incongruent with Western culture, especially approaches that are illegal. For example, the parenting attitudes of Asian Indian mothers living in the United States differ from those in India, and 1 study found that the latter favored corporal punishment, had more inappropriate expectations developmentally, and tended to reverse roles with their children (more frequently endorsing such items as "young children should be expected to comfort the mother when she is feeling blue").[81] In some Muslim American families, arranged marriages, the significance of showing respect to parents, and polygamy are issues that can cause conflicts.[82] It is also important to address parent–child boundary issues that may become problematic with the child's increasing acculturation. For example, as part of their emphasis on the family, Chinese immigrant parents sleep in closer proximity to their children and place a greater emphasis on the inhibition of expression, less emphasis on children expressing their needs, and less importance on children's intimacy and pleasure.[83]

Principle 12. Clinicians should preferentially use evidence-based psychological and pharmacologic interventions specific for the ethnic/racial population of the child and family they are serving.

The Surgeon General's supplement on culture, race, and ethnicity[7] pointed out the racial/ethnic disparity in the evidence base for various psychiatric and psychological interventions as a result of a lack of evaluation of such interventions in minority populations. Much of the research disparity has been the result of over-representation of Euro-Americans and inadequate recruitment of minorities into clinical trials, such that most of the presumed evidence-based interventions in mental health lack sufficient evidence for specific racial and ethnic/cultural groups.

In recent years, however, there has been a growing literature evaluating the efficacy of various forms of psychotherapy and community-based interventions in diverse children and

youth.[71,84] It is incumbent on clinicians to preferentially use evidence-based interventions with specific population-based evidence. Psychotherapeutic interventions demonstrating evidence with diverse populations include cognitive-behavioral therapy for treatment of depression in Latinos and African Americans,[72,85] interpersonal psychotherapy for treatment of depression in Latinos,[85] cognitive-behavioral therapy for treatment of anxiety disorders in Latinos,[86] group cognitive-behavioral therapy for anxiety disorders in African Americans,[87] trauma-focused cognitive psychotherapy and peer-mediated treatment for traumatic stress for African Americans,[88] and manualized family therapy for the treatment of substance abuse for Latinos.[89] Most of these studies have involved culturally adapted protocols. Community-based interventions with racial-/ethnic-specific evidence include multisystemic therapy for conduct disturbances, substance abuse, and suicidality in African Americans, Asian Pacific Islanders, and Latinos[90]; school-based cognitive-behavioral interventions for treatment of depression in African Americans and Latinos[91]; and school-based cognitive-behavioral interventions for trauma in Latinos.[75] Many evidence-based interventions have been evaluated with African American and Latino youth with conduct problems, with more than a dozen of these distinct treatments having been successfully tested in randomized trials.[72]

Relatively less evidence exists for pharmacologic interventions; however, some data are available for diverse populations. For example, the Treatment of Adolescent Depression Study[92] had a 26% minority representation among its participants (principally Latino and African American), and minority status was found not to be a significant moderator of acute treatment outcome using combined cognitive-behavioral psychotherapy and pharmacotherapy. However, no separate data analyses on the effectiveness of the treatments examined have been published. In the Multisite Treatment Study of Attention-Deficit/Hyperactivity Disorder, inner-city African Americans and Latinos required combination stimulant pharmacotherapy and cognitive-behavioral intervention to achieve equal outcomes to white children, who required only stimulant pharmacotherapy.[93]

Principle 13. Clinicians should identify ethnopharmacologic factors (pharmacogenomic, dietary, use of herbal cures) that may influence the child's response to medications or experience of side effects.

It is important to avoid the harmful stereotyping around race and genetics of the past and to adopt a new approach to the consideration of biological and genetic factors that serves the goal of addressing health disparities.[94] Although most genetic variation is shared worldwide, the relative proportion of functional genetic variants for any given gene may vary by ancestry. This in theory can lead to different patterns of medication metabolism and activity and risk for side effects. Ethnopsychopharmacology has focused on the study of pharmacogenomic risk alleles that vary in frequency across different ethnic and racial populations, raising questions about the importance of these factors in prescribing. These include the distribution of rapid, slow, and super-slow activity of cytochrome P450 (CYP) isoenzymes (especially CYP2D6 and CYP2D19) across different racial and ethnic populations and polymorphisms of the serotonin 2A and dopamine D3 receptors related to antipsychotic and antidepressant treatment response.[95,96] These differences have been associated with reports of African Americans (and Caribbean Latinos with African heritage) experiencing lesser response to serotonin reuptake inhibitors and more frequent extrapyramidal side effects with antipsychotics, and Asians having a larger percentage of slow metabolizers and often experiencing Western medicines as being "too strong" with many side effects.[96,97]

Despite extensive pharmacogenomic research, there are few identified genetic variants with definitive clinical utility.[98] There is a vast number of genes involved in medication response and metabolism, particularly for drugs with CNS activity. Much of the focus to date has been on the effects of genes on enzymes responsible for phase I metabolism (e.g., CYP enzymes), receptor regulation, and receptor transporters. Genetic variants within these classes of genes have been variably associated with differential treatment response and side effect profiles. However, the effect sizes are small, and the specific risk variants are often not consistently replicated in other studies.[98]

Using race or ethnicity as a solitary marker for specific pharmacogenomic profiles raises some confounds.[99] The human genome is enormously complex, the predominance of genetic variation in the human genome is shared across all human populations, yet individuals are genetically

unique.[100] Alleles that vary widely in frequency across different human populations often have no functional significance.[101] Alleles with widely varying frequencies based on ancestry also are prone toward false positive findings in genetic association studies, a phenomenon known as *population stratification.* In addition, racial intermixing in modern populations renders generalizations around genetics meaningless.

One meta-analytic review of ethnic differences in tolerability of psychotropic drugs did not find significant differences.[102] However, to date there has been significant under-recruitment of diverse populations into randomized controlled studies, thus limiting the validity and generalizability of such results. Newer studies focusing on pharmacogenetic variables, particularly with adults, are much more careful about participant recruitment, phenotypic classification, and controlled designs with adequate numbers of diverse participants to control for population stratification bias.[94] For example, using an ethnically stratified analysis to control for population stratification, a study of the putative role of the dopamine D3 receptor in tardive dyskinesia found that patients homozygous for the glycine variant of the *DRD3* gene had significantly higher Abnormal Involuntary Movement Scale (AIMS) scores, and African Americans had a significantly higher prevalence of this polymorphism.[103]

Gene-by-environment interactions are also important in predicting medication response and further complicate the use of race or ethnicity as a simple pharmacogenomic predictor.[99] For example, grapefruit juice may increase serum concentrations of nefazodone and alprazolam by affecting the CYP3A4 isoenzymes and corn diets may increase serum concentrations of selective serotonin reuptake inhibitors by affecting CYP2D6 isoenzymes.[97] Thus, the dietary practices of different cultural groups need to be considered when prescribing.[96] Such practices may change as individuals migrate to different regions and adopt the practices of their new community. In addition, findings of interactions between stressful life events and genetic polymorphisms in serotonin transporter genes in the expression of major depression may present even greater confounds for minority and underserved populations chronically exposed to such stress.[104]

Thus, at this time, although there is great promise for pharmacogenomics to advance personalized medicine, further research is needed to identify genetic factors with definitive impact on treatment response and side effect profiles. Until such findings are available, clinicians should exercise caution in prescribing and dosing psychopharmacologic agents for diverse patients. They should base decisions on the individual's clinical and familial histories, migration and ancestral histories, personal and familial histories of pharmacologic response, and dietary history.[96] Currently available pharmacogenomic testing may have some limited utility in cases of diverse children with mixed racial/ethnic background and atypical pharmacologic response.[98]

It is important that clinicians inquire about and discuss the use of alternative medicinal and herbal remedies by culturally diverse youth and families. Western medicine has not eclipsed traditional medicine, and the 2 are often practiced simultaneously or sequentially. Herbs and other traditional remedies sometimes have strong active ingredients, such as atropinic substances that can produce anticholinergic side effects and even toxicity. Many patients and families do not inform their doctor they are consuming these substances unless asked directly.[96] When these do not pose any adverse interaction or might even be beneficial, clinician acceptance of their use can help to build the therapeutic alliance and acceptance of Western therapeutic approaches.

PARAMETER LIMITATIONS

AACAP Practice Parameters are developed to assist clinicians in psychiatric decision making. These parameters are not intended to define the sole standard of care. As such, the parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources. &

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