Working towards MH Equity: The Imperative Role of Cultural Humility

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Land and Labor Acknowledgement

“We acknowledge that we are living off the taken ancestral lands of the Indigenous peoples for thousands of years. We acknowledge the extraction of brilliance, energy and life for labor force upon people of African descent for more than 400 years. We celebrate the resilience and strength that all Indigenous people and descendants of Africa have shown in this country and worldwide. We carry our ancestors in us, and we are continually called to be better as we lead this work.”

- From the American Medical Association’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity 2021-2023
Brave Space Reminder

• Privacy
• Commit to learning
• Promote inclusivity and respect
• Be mindful of language
• Consider our assumptions and/or generalizations about a member of a class or social group(s)
• Step up, step back
• Compassion for others and ourselves in the learning process
• We will work to create as much psychological safety as possible while acknowledging that discomfort will occur
Conflict of Interest Disclosure

We have no actual or potential conflicts of interest in relation to this program or presentation to disclose.
Institutional Disparities

Health Disparities are Driven by Social and Economic Inequities

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Health and Well-Being:
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
"overlapping or intersecting social identities and related systems of oppression, domination, or discrimination."

INTERSECTIONALITY

SEXUALITY  GENDER  ETHNICITY
CLASS  RACE
RELIGION  AGE
EDUCATION  LANGUAGE  HISTORY  HERITAGE
To consider when thinking about intersectionality....
Factors that Maintain Mental Health Disparities

- Implicit bias (Sue et al., 2009; Hall et al., 2015)
- Mental health stigma and negative internalized beliefs (Alverson et al., 2007)
- Silence gap in the comfort levels of mental health providers in addressing racism, and most specifically, racial trauma (Hemmings & Evans, 2018)
- Language barriers
- Lack of diversity in treatment providers
- Cultural beliefs regarding mental health/healing
- Reduced economic resources
- Inaccurate or inadequate diagnosis and treatments
Behavioral/Mental Health Equity

• “The right to access quality health care for all populations regardless of the individual’s race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location.”

• In conjunction with quality services, this involves addressing social determinants, such as employment and housing stability, insurance status, proximity to services, culturally responsive care – all of which have an impact on behavioral health outcomes.

SAMSA, 2022

• The problem that we continue to witness is significant disparities in the screening, prevention, diagnosis, and treatment of mental health issues for racial and ethnic minorities compared with majority group counterparts.

• Attaining mental health equity, requires seeking to understand the wide range of factors that impact health outcomes at multiple social-ecological levels and inform culturally informed treatment.
Culture can be viewed through multiple lenses...

- Race
- Ethnicity
- Religion
- Gender
- Sexual orientation
- Physical disability
- Veteran status
- Era
- Age
- Combat Status
- Branch/MOS
- Education/SES
- Rank
Some caveats:

Everyone has multiple cultural identities

Within group variation can often be minimized while between group variation is exaggerated

Culture is a context; it does not define an individual
Where to start?

BIG TASK

Small TASK
Crucial for culturally sensitive evaluations and treatment

Think about differences between multicultural competency vs. multicultural orientation (humility) in the context of evaluation, case conceptualization, and treatment (Owen, 2013)

**Multicultural competence**

- Acquisition of knowledge and skills to work with people from diverse backgrounds.

**Multicultural orientation**

- The helper’s way of being with others based on the helper’s values and philosophy regarding the value of culture in people’s lives.

- Cultural humility is a core facet of multicultural orientation.
Defining Humility

- **Intrapersonal** - having an accurate view of oneself.

- **Interpersonal** – other-oriented rather than self-focused, characterized by a lack of superiority toward and respect for others.

(Davis et al., 2011)
Cultural Humility

Desire and ability to maintain an other-oriented interpersonal stance in relation to features of cultural identity that are important to others. (Hook et al., 2013)
Cultural Humility

• Three dimensions of cultural humility:

INWARD: self-awareness

OUTWARD: valuing others/
accurate evaluation

UPWARD: growth/
effective clinical
treatment
Other points to Consider

• “Cultural humility, by definition, is larger than our individual selves — we must advocate for it systemically” (Waters & Asbill, 2013)

• Cultural Humility- parallels with “growth mindset”

• It acknowledges a power imbalance between providers and patients.
  • The role of the expert shifted from the doctor to the patient

• The components of cultural humility—other-orientation grounded in respectfulness and lack of superiority—are attributes that can be encouraged in individuals to breed more fertile ground for inclusive, healthy team atmospheres, contributing to a variety of positive team and business outcomes.
Applying Cultural Humility Concepts

• In the context of what you just learned, how would you apply your knowledge when working with individuals from the various marginalized communities in your area?

• How would this impact your training of future mental health providers?

• What impact do you think it would have on your day-to-day interactions with individuals from your same ethnic/racial backgrounds?

• How would this be different/similar to your interactions with individuals from other ethnic/racial backgrounds?
Vignettes
Clinical Vignette 1

• Victor is a 27-year-old European-American man who comes to you for help at the urging of his fiancée. He was an infantryman with a local Marine Reserve unit who was honorably discharged in 2014 after serving two tours of duty in Iraq. His fiancé has told him he has “not been the same” since his second tour of duty and it is impacting their relationship. Although he offers few details, upon questioning he reports that he has significant difficulty sleeping, that he “sleeps with one eye open” and, on the occasions when he falls into a deeper sleep, he has nightmares. He endorses experiencing several traumatic events during his second tour but is unwilling to provide specific details – he tells you he has never spoken with anyone about them, and he is not sure he ever will. He spends much of his time alone because he feels irritable and doesn’t want to snap at people. He reports to you that he finds it difficult to perform his duties as a security guard because it is boring and gives him too much time to think. At the same time, he is easily startled by noise and motion and spends excessive time searching for threats that are never confirmed both when on duty and at home. He describes having intrusive memories about his traumatic experiences on a daily basis, but he declines to share any details. He also avoids seeing friends from his Reserve unit because seeing them reminds him of experiences that he does not want to remember.
Clinical Vignette 1

Victor is a 57-year-old gay-identified Latinx cis man who comes to you for help at the urging of his fiancee. He was an infantryman with a local Marine Reserve unit who was honorably discharged in 2014 after serving two tours of duty in Iraq. His fiance has told him he has “not been the same” since his second tour of duty and it is impacting their relationship. Although he offers few details, upon questioning he reports that he has significant difficulty sleeping, that he “sleeps with one eye open” and, on the occasions when he falls into a deeper sleep, he has nightmares. He endorses experiencing several traumatic events during his second tour but is unwilling to provide specific details — he tells you he has never spoken with anyone about them, and he is not sure he ever will. He spends much of his time alone because he feels irritable and doesn’t want to snap at people. He reports to you that he finds it difficult to perform his duties as a security guard because it is boring and gives him too much time to think. At the same time, he is easily startled by noise and motion and spends excessive time searching for threats that are never confirmed both when on duty and at home. He describes having intrusive memories about his traumatic experiences on a daily basis, but he declines to share any details. He also avoids seeing friends from his Reserve unit because seeing them reminds him of experiences that he does not want to remember.
Clinical Vignette 2

Mary is a 26-year-old European-American woman who presents with a history of non-suicidal self-injury, specifically cutting her arms and legs, since she was a teenager. She has made two suicide attempts by overdosing on prescribed medications, one as a teenager and one six months ago; she also reports chronic suicidal ideation, explaining that it gives her relief to think about suicide as a “way out.”

When she is stressed, Mary says that she often “zones out,” even in the middle of conversations or while at work. She states, “I don’t know who Mary really is,” and describes a longstanding pattern of changing her hobbies, style of clothing, and sometimes even her job based on who is in her social group. At times, she thinks that her partner is “the best thing that’s ever happened to me” and will impulsively buy him lavish gifts, send caring text messages, and the like; however, at other times she admits to thinking “I can’t stand him,” and will ignore or lash out at him, including yelling or throwing things. Immediately after doing so, she reports feeling regret and panic at the thought of him leaving her. Mary reports that before she began dating her current partner she sometimes engaged in sexual activity with multiple people per week, often with partners whom she did not know.
Clinical Vignette 2

Mary is a 26-year-old African-American trans woman who presents with a history of non-suicidal self-injury, specifically cutting her arms and legs, since she was a teenager. She has made two suicide attempts by overdosing on prescribed medications, one as a teenager and one six months ago; she also reports chronic suicidal ideation, explaining that it gives her relief to think about suicide as a “way out.”

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https://div12.org/case-studies/#


