

A Four-Year Model Curriculum on Culture, Gender, LGBT, Religion, and Spirituality for General Psychiatry Residency Training Programs in the United States

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Introduction

The increasing cultural diversity of the United States, as shown by the most recent U.S. Census data, requires that clinicians understand how cultural differences affect diagnosis and treatment. Between 1980 and 2000, the number of Asian Americans increased by 230%, American Indians by 139%, Hispanic Americans by 142%, and African Americans by 32%. In contrast, the Caucasian population increased by 11% (1). In addition, Accreditation Council of Graduate Medical Education (ACGME) requirements for psychiatric residents now include a familiarity with cultural assessment (2), and the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR) has added new emphasis to the influence of culture on diagnosis by including an Outline for Cultural Formulation (OCF) and a Glossary of Culture Bound Syndromes (3).

Recent publications, such as the Surgeon General's Supplement to the Report on Mental Health, "Culture, Race, and Ethnicity" (2001) (4), which states that "culture counts," and the Institute of Medicine's Unequal Treatment (2002) (5) indicate that ethnic minority patients have less access to services and receive a lower quality of medical and psychiatric treatment. Other documents such as the Culturally and Linguistically Appropriate Services (CLAS) Standards (fourteen system standards about culturally competent care, language access services and organizational supports for cultural competence) (6); the Center for Mental Health Services (CMHS) report, Managed Mental Health Care Services for Four Underrepresented/Underserved Groups, (7); the California Endowment's reports Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals – 2003 (8), A Manager's Guide to Cultural Competence Education for Health Care Professionals – 2003 (9), and

Resources in Cultural Competence Education for Health Care Professionals – 2003 (10); the Commonwealth Fund Report (11); and the Clinical Manual of Cultural Psychiatry (12) suggest ways in which we can train health and mental health professionals to provide and to design culturally competent services, including evaluation of such services that are appropriate for underserved patients.

Background Information and History

We believe that the success of our cultural curriculum has been due to three factors: 1) A critical mass of committed ethnic minority faculty, 2) a supportive administration, and 3) a diverse patient population. The Diversity Advisory Committee (DAC) was founded in 1999 by its current Chair, Russell Lim, MD, to address and develop diversity issues within the UC Davis Department of Psychiatry and Behavioral Sciences. Our goals were to improve instruction in cultural competence in graduate and undergraduate medical education; improve services for ethnic minority patients by recruiting minority medical students, residents, and faculty; and to encourage scholarly work such as publications and research. DAC has also supported the development of a four-year Religion and Spirituality curriculum for the general psychiatry residency program, which received a Templeton Foundation Curricular Award in 2003, as part of a four-year Cultural Psychiatry curriculum. The American College of Psychiatrists (ACP) awarded its Creativity in Psychiatric Education in 2007 to the UC Davis Department of Psychiatry and Behavioral Sciences for the Diversity Advisory Committee. We have at least two Grand Rounds Speakers per year who present on issues in cultural psychiatry. Finally, we have conducted four successful Continuing Medical Education (CME) symposiums in the last nine years, co-sponsored a fifth last year, as well as a Faculty

Development Seminar that was held jointly with the University of California, San Francisco, on cultural psychiatry topics.

Our other goals have been to recruit minority undergraduates, medical students, residents and faculty to join the UC Davis School of Medicine and become teachers of cultural psychiatry. We are active in interviewing medical school applicants, residency applicants, and faculty applicants. DAC actively recruits residents to apply for the American Psychiatric Association (APA) Minority Fellowships, and we have had ten fellows in the last eleven years. We were also successful in recruiting Francis G. Lu, MD to be the Luke and Grace Kim Endowed Professor in Cultural Psychiatry.

Finally, DAC encourages academic scholarship. Members of DAC have received grants for research in geriatrics, and medical education and have published three articles and an editorial in a special issue of Academic Psychiatry on Culture and Psychiatric Education, and one in Adolescent Psychiatry, and have authored numerous book chapters, as well given presentations nationally. Three of our members have been honored for their contributions with the UC Davis Chancellor's Award for Diversity and Community.

The second key is administrative support. Our Chairman, Robert E. Hales, MD, MBA, has been supportive from the beginning, by providing both a budget for our grand rounds speakers, and providing us a seat on the Psychiatric Academic Council, which oversees the academic mission of the department. The Residency Training Director (Mark E. Servis, MD) has been equally supportive by allowing us to develop new required courses in the Residency program. DAC now has several representatives on the Training and Education Committee (TEC), which oversees residency training, including

curriculum. However, no program can be successful without a core group of faculty. DAC is an integral part of the infrastructure of the UCD Department of Psychiatry and Behavioral Sciences and provides needed support for critical programs. Finally, DAC is also an important part of the Dean's Council on Diversity, and we hope to bring more cultural competence to the medical center and medical school. DAC holds an annual retreat in August to review goals from the previous year and to set goals for the next. DAC meets monthly to encourage scholarly work and develop our projects agreed upon at the annual retreat.

The clinical population in Sacramento County lends relevance to our educational programs with its wide diversity of languages and cultures represented. For example, an article in Time magazine called Sacramento the most diverse city in the United States in September of 2002 (13). Sacramento County has seven threshold languages (Cantonese, Hmong, Lao, Mien, Russian, Spanish, Vietnamese), as defined by the California Cultural Competence Plan (14) as 5% of the Medicaid population or 3000 members, that speak that language, which is second only to Los Angeles County, which has eight. Yet few of the department's educational activities in 1998 addressed the issues of how to serve a culturally diverse population. We now feel that we can design and deliver a cultural curriculum that can develop attitudes that support culturally competent care, teach important cultural specific knowledge, and encourage the development of culturally generic skills that lead to culturally appropriate assessment and treatment. Other programs should perform a similar needs analysis of their patient population prior to implementing a cultural competence curriculum, and make changes as their needs are discovered and their resources are identified and developed.

Our approach can be stated simply as four guiding principles: 1) teach attitudes that value acceptance of diverse cultural beliefs and worldviews, 2) demonstrate skills that are culture generic, 3) teach knowledge that is culture specific, and 4) teach culturally adapted techniques that are supported by evidence in peer-reviewed journals. The sources for our inspiration are many, and this model curriculum represents the best of what we have created in other settings added on to the original ACP award-winning curriculum. We owe a great debt to the dedicated teachers that served as faculty in the APA Annual Meeting Continuing Medical Education (CME) course entitled DSM-IV Cultural Formulations: Assessment and Treatment, that the first author (RFL) directed annually for thirteen years that led to the publication of the book Clinical Manual of Cultural Psychiatry, which was based on the assumption that the use of the DSM-IV OCF, along with culturally based knowledge would help to develop cultural competence. We also acknowledge material developed and inspired by Sunita Mutha and Mary Walton in their annual seminar at UCSF, Addressing Health Disparities: Cultural Competency Faculty Development Program (15), which in turn inspired our second APA Annual Meeting CME Course, Culturally Appropriate Assessment Made Incredibly Clear- A Skills-based Course with Hands-On Experiences.

While the UC Davis cultural psychiatry curriculum is designed to be relevant for the culturally diverse patient population seen by our general psychiatry residents, we acknowledge there are inadequacies. To generalize its use in other general psychiatry residency programs, as well as address under-represented topics, we have added sections on Native American and LGBT topics to our model. The limitations to applying our curriculum are that the curriculum should be tailored to the patient population seen, and

be taught by faculty experienced with working with the identified ethnic groups. Teaching all of the included material may exceed the available time in the residency curriculum. In that case, we would suggest the prioritization of mental health disparities, attitude development, skills development, general informational sessions, and cultural formulation presentations. We would also suggest prioritizing the films, perhaps omitting most films except The Color of Fear, in the most time-limited scenario. Some of the psychotherapy material may be incorporated in a case conference format using the DSM-IV-TR OCF, which would not take up any extra curricular time, as case conferences are not thought of as being part of the formal didactic curriculum.

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Goals:

1. To fulfill 2007 ACGME RRC accreditation standards for general psychiatry residency programs that focus on sociocultural issues (underlined and in italics) for five of the six core competencies as follows:
 - 1) Patient care
 - a) "Residents must have supervised experience in the evaluation and treatment of patients. *These patients should be of different ages and gender from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds.*"
 - b) "Residents should develop competence in formulating a clinical diagnosis for patients by conducting patient interviews, eliciting a clear and accurate history; performing physical, neurological, and mental status examination, including appropriate

diagnostic studies; completing a systematic recording of findings; relating history and clinical findings to the relevant biological psychological, behavioral, and sociocultural issues associated with etiology and treatment”

2) Medical knowledge

“The didactic curriculum must include the following specific components:”

a) “the biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle”

b) “the fundamental principles of the epidemiology, etiologies, diagnosis, treatment, and prevention of all major psychiatric disorders in the current standard diagnostic statistical manual, including the biological, psychological, sociocultural, and iatrogenic factors that affect the prevention, incidence, prevalence and long-term course and treatment of psychiatric disorders and conditions”

c) “an understanding of American culture and subcultures, particularly those found in the patient community associated with the educational program, with specific focus for residents with cultural backgrounds that are different from those of their patients”

d) “[the] use of case formulation that includes neurobiological, phenomenological, psychological, and sociocultural issues involved in diagnosis and management of cases”

3) Interpersonal and communication skills

a) “Residents are expected to.... communicate effectively ..., with patients, their families, and the public across a broad range of socioeconomic and cultural backgrounds”

b) “[Residents need to proficient at] demonstrating sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation”

4) Professionalism

a) “Residents are expected to demonstrate... sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.”

5) Systems-based practice

a) “Residents are expected to advocate for quality patient care and assisting patients in dealing with system complexities, including disparity in mental health care”

Summarizing, our goals are:

1. To have trainees understand the impact of culture on assessment/formulation,

diagnosis and treatment of mental disorders

2. To improve treatment outcomes of all patients by effectively bridging the patient's worldview and the clinician's treatment plan and collaborating with the patient's social network

3. To reduce mental health disparities by teaching trainees specific skills and knowledge to effectively treat all under-served groups

Objectives:

Skills:

Year One-Introduction to Cultural Psychiatry

1. To understand one's own cultural identity

Year Two-Cultural Psychiatry

2. To be able to use the DSM-IV-TR OCF to inform the clinical interview, which includes many of the goals listed below
3. To assess a cultural identity
4. To assess an explanatory model
5. To assess religious/spiritual issues relevant to patient care
6. To interview patients regarding their spiritual/religious values, beliefs, and practices with empathy and sensitivity, and incorporate religious, spiritual and cultural issues in the differential diagnosis, case formulation and treatment plan of patients when appropriate
7. To assess cultural stressors and supports
8. To assess the culture elements of the relationship between the patient and clinician
9. To be able to use an interpreter effectively
10. To be able to recognize the impact of culture on symptom presentation and assessment
11. To be able to recognize the impact of culture on treatment planning

Year Three-Psychotherapy and Culture

12. To understand how to adapt cognitive therapy and supportive therapy to underserved populations, such as Cambodians and Hispanics

Year Four- Advanced Cultural Psychiatry

13. To write and present a case presentation using the DSM-IV-TR OCF
14. To be able to use a cultural consultant

Attitudes:

Year One

1. To understand their own cultural identity
2. To begin to understand one's own cultural systems
3. To develop awareness and acceptance of differences between their own worldview and those of others

4. To understand how to take a spiritual/religious history and when to ask for a more thorough assessment
5. To be aware of one's own spiritual experiences and values, and be willing to overcome personal biases and discomfort in addressing spiritual/religious issues in patient care
6. To appreciate spiritual and religious diversity of their patients and colleagues, while being sensitive and responsive of patients from a variety of religious and spiritual backgrounds
7. To be respectful of the services provided by chaplains, clergy, and spiritual leaders, including a willingness to collaborate in the medical and emotional care of patients who are ill and/or dying, and their families
8. To understand the culture of medicine and its impact on one's work and life

Year Two

9. To understanding the impact of racism, sexism, heterosexism, and religious bias on patient's lives

Knowledge: To understand the following topic areas

Year One

Introduction to spirituality and religion in psychiatry

1. The various ways of defining the terms "spiritual" and "religious"
2. The research data on spiritual and religious beliefs and practices on health care, especially mental health
3. The spiritual and religious worldviews that may be harmful or distorted, and determine appropriate interventions and referrals
4. Approaches to critically assess and discuss the methodologies and conclusions of the research data on spirituality and health care

Year Two-A Background History for Cultural Competence

1. Describe disparities in mental health treatment based on ethnicity
2. Definitions of common terms such as cultural competence, diversity, culture, race, ethnicity, linguistic access, mental health and healthcare disparities
3. Use primary sources to describe the evidence for mental health and healthcare disparities
4. Describe pertinent national and state regulations and policies regarding culturally and linguistically appropriate health care and services (i.e., USDHHS, Office of Minority Health (CLAS), Office of Civil Rights, LEP)
5. Describe how culture shapes health beliefs and values
6. Describe how culture affects help-seeking behaviors and decision-making
7. Discuss how cross-cultural communication and medical

- interpreters can affect the use of health services and outcomes
8. Rationale for using an interpreter
 - a. Improving the quality of care
 - b. Better health outcomes
 - c. Compliance with legal regulations (i.e., Title VI of the Civil Rights Act)
 9. The resident will learn culture specific knowledge about patient populations generally seen, such as historical facts such as reasons for immigration, and basic cultural beliefs and cultural gender and family roles, as well as differing cultural presentations of illness and culture bound syndromes concerning:
 - a. African Americans
 - b. Asian Americans
 - c. Hispanic Americans
 - d. Native Americans
 - e. LGBT individuals
 - f. Women's Health and Mental Health
 10. The effect of race/ethnicity on pharmacology
 11. Cultural aspects of depression

Year Three

12. Understand how to formulate psychotherapy cases by stages of acculturation, racial identity, self identity, and communication styles
13. Learn psychotherapy techniques to use with patients from diverse cultures
14. Be able to identify intra-ethnic and inter-ethnic transference and counter transference
15. The effect of race/ethnicity, gender, and sexual orientation, amongst other cultural identity variables in psychotherapy with:
 - a. African Americans
 - b. Asian Americans
 - c. Hispanic Americans
 - d. Native Americans
 - e. LGBT individuals
 - f. Women

Spiritual/religious issues in psychotherapy

1. Recognize when exploration of spiritual/religious issues may be valuable
2. Understand the difference between healthy and normative spiritual or religious phenomenon from that which is unhealthy and psychopathological
3. Understand the value of patients' spirituality/religion as a source of strength/support and positive coping, versus a source of stress and negative coping

4. Understand types of transference and counter-transference that may occur when exploring spiritual and religious issues with patients, and its effect upon therapy
5. Interview patients regarding their spiritual or religious values, beliefs, and practices with empathy and respect
6. Incorporate spiritual/religious issues in the differential diagnosis, case formulation, and treatment plan of patients, when appropriate
7. Address issues of transference and counter-transference, and determine appropriate interventions, including when the therapist's religious/spiritual affiliations are questioned
8. Be aware of one's own spiritual/religious experiences and values, and how it may influence their consideration of the spiritual/religious issues of patients
9. Recognize when patients may benefit from either further spiritual/religious assessment and from utilizing religious or spiritual resources, including referral to clergy or pastoral counseling

Advanced Cultural Psychiatry- PGY-4

1. The resident will be able to write and present a case in the DSM -IV-TR OCF.
2. The resident will be able to use a cultural consultant to further explore a case from his or her own caseload.

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Instructional Methods

1) Cultural Identity Awareness Exercise- Ask participants to first self-reflect on their current cultural identity, and then introduce themselves considering many possible cultural identity variables: where they are from, what language (s) they speak, race/ethnicity, gender, sexual orientation, socioeconomic status, educational attainment, spiritual/religious beliefs, roles that they play in their life, among others. This exercise

can also be done in pairs first by noting the cultural identity differences between the two persons. Finally, the pairs could share their cultural identity similarities and differences with others in the group. The leader(s) of this exercise may wish to model this process first to facilitate the participants' engagement. A second exercise would be for each person to self-reflect on the development of their cultural identity over time and location changes focusing on times when differences were experienced between the person and others. Then, as with the first exercise, pairs could start the process to discuss between them their experiences of differences and its impact on cultural identity development, and finally sharing can take place in the larger group. This second exercise can also be modeled first by the leader(s).

2) Lectures on cultural generic assessment techniques organized with the DSM-IV-TR OCF and discussion about cases (both published and current unpublished ones), which exemplify the use of the OCF.

- A. Cultural identity of the individual with standardized patient,
- B. Cultural idioms of distress, culture bound syndromes, explanatory models, and treatment pathways with standardized patient,
- C. Cultural stressors and supports with standardized patient,
- D. Cultural elements of the relationship between the clinician and the individual.
- E. Overall assessment for differential diagnosis and treatment planning with standardized patient.

3) Lectures and discussion on culturally specific knowledge issues.

4) A journal club can supplement site-specific learning, as would case conferences using the DSM-IV-TR OCF. Residents are expected to write and present

cases incorporating the OCF.

5) Videos as a stimulus for discussion. Examples include: The Color of Fear to discuss racism (Lim, Diamond, Chang, et al), For the Bible Tells Me So, to discuss homophobia, The Alternative Fix, to discuss complimentary and alternative medicine, The Pill, to discuss women's health issues, The Culture of Emotions, to discuss the DSM-IV-TR OCF, and Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans, to discuss the stigma of mental illness in Asian Americans.

6) Videotaped case material showing a demonstration of skills, followed by a practice session with a standardized patient, followed by formative evaluation with standardized patients.

7) Online learning, such as the use of the Association of Gay and Lesbian Psychiatrists, LGBT Mental Health Syllabus at <http://www.aglp.org/gap>.

Instructor Preparation

Instructors must be familiar with the main concepts of cultural competence, including mental health/healthcare disparities, federal and state initiatives, and be aware of their own cultural identity and biases. All instructors should be familiar with the curricular material, and would be expected to have completed a cultural identity awareness exercise, complete reading of articles and viewing of tapes. The instructor would receive training in evaluating cultural assessment skills with the use of standardized patients. Instructors will also be given a training entitled- "A Train the Trainer's Workshop." Ideally, instructors should have clinical experience in working with culturally diverse patients including from ethnic minority groups.

Expectations of Learners

Learners are expected to approach the curriculum with an open mind, to share personal experiences with racism and other biases based on cultural identity and working with other cultural groups, to be mindful of cultural factors in all patient interactions, to read all articles prior to lecture, and to bring in case examples for discussion using the DSM-IV-TR OCF.

Creativity and Innovation

Our curriculum is comprehensive and developmental. It recognizes that culture specific knowledge is necessary but insufficient as well as potentially promoting stereotypes when it is the sole focus of the curriculum. Culture generic cultural competence skills must be demonstrated, taught, and evaluated for a minimum level of proficiency. It emphasizes the concept of “just in time” learning, or developmentally appropriate objectives which teaches the concepts at a time in their training when residents are most likely to use them, such as psychotherapy skills during the usual third year outpatient experience. The curriculum emphasizes actual performance and evaluation of skills using standardized patients in lecture and informative evaluation. We have created our own training materials with a unique set of videotaped cases using a Caucasian interviewer and standardized patients to demonstrate the use of the OCF in interviewing.

Course outlines

Two Phases:

Culture-generic skills and attitudes, then culture-specific knowledge.

Year one

Cultural identity awareness and the culture of medicine (Lurhman)

Cultural introductions

Discussion Group Questions for Cultural Identity Awareness Exercise (Modeled after E. Pinderhughes)

1. What is your cultural identity?
2. What was your first experience with feeling different?
3. What is your ethnic background?
4. What has it meant to belong to your ethnic group?
5. How has it felt to belong to your ethnic group?
6. What do you like about your ethnic identity?
7. What do you dislike?
8. What are your feelings about being White or a person-of-color?
9. How do you think others feel?

Spiritual History and Assessment- 2 sessions (Koenig, Koenig and Sloan, Pulchalski)

Year two

Rationale for cultural competence, (ACGME, RRC accreditation core competences on sociocultural issues)

Health and mental health disparities (Lim, Lu, Hilty) (Lim)

Supplement to Surgeon General's Report on Mental Health (USDHHS)

Unequal Treatment (Smedley, et al)

The business case for cultural competence (Brach, Frasierrector)

Stereotypes vs. Generalizations (Mutha, Welsch)

CLAS standards (OMH)

The DSM-IV-TR Outline for Cultural Formulation and assessment skills
(APA, Caraballo, et. al., Ton, Lim)

Cultural Identity:

The "Addressing" acronym (Hays) is a good starting point for the assessment of cultural identity.

Age and generational influences

Developmental and acquired

Disabilities

Religion and spiritual orientation

Ethnicity

Socioeconomic status

Sexual orientation

Indigenous heritage

National origin

Gender

Additional cultural identity variables to consider:

1. Language (s) spoken or preferred
2. Acculturation

3. Gender/ Gender Identity
4. Ethnicity
5. Nationality
6. Sexual orientation
7. Religious or spiritual group
8. Political orientation
9. Vocational identity
10. Geographic location (i.e., rural, urban, suburban)

How? Developmental, social history, or direct questioning.
Standardized Patient exercise- Part A of OCF

Idioms of Distress

1. Dizziness
2. Fatigue
3. Pain- headaches, backaches, stomach aches
4. Evil spirits

Culture Bound Syndromes

1. Ataque de Nervios
2. Neurasthenia (Shenjing Shuairuo)

Explanatory Models (Ton, Lim)

1. Magic- Evil Eye
2. Religious- Punishment
3. Moral- Laziness, selfishness, weak will
4. Medical- Ayurveda, Chinese Traditional Medicine, Homeopathy, osteopathy, herbal treatments, etc.
5. Psychological Stress

Kleinman's Questions (Kleinman)

1. What do you call your illness? What name does it have?
2. What do you think has caused the illness?
3. Why and when did it start?
4. What do you think the illness does? How does it work?
5. How severe is it? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?
7. What are the chief problems the illness has caused?
8. What do you fear most about the illness?

Standardized Patient exercise- Part B of OCF

Standardized patient exercise- Part C- Cultural stressors and supports, spiritual assessment

Film example Part D- (Bland or Lim, Lu cases)

Standardized Patient exercise- Part E- Explaining the treatment plan, including the patient's explanatory model and LEARN (Caraballo, et al)

The Culture of Emotions- The DSM-IV-TR OCF (Lu, Koskoff)

The Color of Fear- Exploring feelings about racism (Lee Mun Wah)

How to use an Interpreter (Lee)
American culture-Our culture and what it means to others
Chapters from Clinical Manual of Cultural Psychiatry

Ethnopsychopharmacology (Smith)
African Americans (Primm)
Asian Americans (Du)
Hispanic Americans (Laria, Lewis-Fernandez)
Native Americans (Fleming)

Trauma and Substance Abuse

LGBT- (AGLP- LGBT Curriculum)

The History of Psychiatry and Homosexuality
Taking a Sexual History with LBG T Patients
Psychological Development & Life Cycle
Psychotherapy
Medical and Mental Health
Transgender
Intersex
Diversity / People of Color

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Culture and Depression (Lim, Ton)

Journal club: Explanatory models (Kleinman), Racism and misdiagnosis (Adebimpe), Cognitive behavioral therapy (Otto and Hinton, Hinton and Otto), Ethnography (Culhane Pera K), PTSD and Latinos.

Formative evaluation with standardized patients and feedback on videotaped interview, focusing on verbal and non-verbal communication.

Year Three

Adapting psychotherapy techniques and assumptions (references 43-68)

Introduction to psychotherapy and culture

Definitions

Assumptions in Western psychotherapy

Acculturation

Communication and listening culturally

Norms

Techniques

Barriers to multi-cultural therapy

Communication style differences

Ethnocultural transference and counter-transference (Comas Diaz, Jacobsen)

Supervision and ethnicity (Tumula-Nara)

Identity- Racial identity and cultural self-identity

Practical clinical strategies

Culturally Alert Counseling: A Comprehensive Introduction- DVD (McAuliffe)

Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans- Lu

Video Case examples- Strategies to overcome Barriers to effective psychotherapy

Hispanic issues in psychotherapy- (Arrendondo)

The ten commandments of marianismo

Spanish phrases and metaphors

Psychotherapy and African Americans (Parham)

Rituals and symbols

“Life at its best is a creative synthesis of opposites in fruitful harmony.”

Examples

Cognitive Therapy in Cambodians- (Otto and Hinton, Hinton and Otto)

CBT in Hispanics- (Interian, Díaz-Martínez)

The therapist variable- (Kinzie)

Group therapy with Vietnamese patients- (Truong and Gutierrez)

Therapy in African Americans- (Parham, Bland, Post)

Therapy in Latinos- (Arrendondo)

Therapy in Native Americans- The use of Ritual in therapy (Gone)

Case Conferences incorporating the DSM-IV-TR OCF

Year Four

Gender and Sexuality

Gender identity in development- watch and discuss excerpts from BBC

Documentary, “7 & Up.”

Erotic transference and counter-transference- watch and discuss vignette from HBO series, “In Treatment.”

Female and male sexual dysfunction

Paraphilias

The effect of psychotherapist gender on therapeutic alliance

Gender Identity and Transgender health and mental health

Perimenopause

Sexual side effects of psychotropic medications

Advanced Cultural Psychiatry- Each senior resident presents a case incorporating the DSM-IV-TR OCF with a cultural consultant present to facilitate discussion (Lewis-Fernandez and Diaz, Chung and Lin, McGoldrick, Giordano and Garcia-Preto)

â€¢ A Four-Year Model Curriculum on Culture, Gender, LGBT, Religion, and Spirituality for General Psychiatry Residency Training Programs in the United States. Save to Library. Download.â€” Page 60. CHAPTER 3 Cultural Competence in Violence Risk Assessment

Russell F. Lim, MD Carl C. Bell, MD The impact of cultural factors on the assessment of the risk of violence is complex and multifactorial. In earlier chapters Save to Library. by Russell Lim. â€¢ 12 cross-cultural issues in therapy with an asian american adolescent. Save to Library. by Russell Lim. â€¢ Clinical Manual of Cultural Psychiatry (paperback). Clinical Manual of Cultural Psychiatry (paperback) LIM Russell F. Save to Library. by Russell Lim. (1997). Model Curriculum for Psychiatry Residency Training Programs: Religion and Spirituality in Clinical Practice . (Revised Edition), Rockville, Maryland: The National Institute for Healthcare Research. Very important for those planning curriculum in this area. Larson, D. B., Swyers, J. P., & Mccullough, M. E. (Eds.). (1998). Scientific Research on Spirituality and Health: A Consensus Report . (revised edition), Rockville, MD: National Institute for Healthcare Research (NIHR). An extraordinary synthesis of the research literature. *Lee, E. (Ed.). Each residency program is responsible for its own curriculum. This guideline provides a useful strategy to help residency programs form their curricula for educating family physicians.â€” Training programs should recognize that low numbers of LGBT patients may be due to a lack of recognition or lack of a welcoming atmosphere on a system level and should act to create appropriate changes. All clinics and programs should perform appropriate outreach to the LGBT community in order to welcome patients, faculty, residents, and staff.â€” Deutsch MB. Use of the informed consent model in the provision of cross-sex hormone therapy: a survey of the practices of selected clinics. Int J Transgend.