Intercultural Competence and Patient-Centered Care

Faculty
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This activity has been designated for 4 Lifelong Learning (Part II) credits for the American Board of Pathology Continuing Certification Program.

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NetCE designates this continuing education activity for 4 ANCC contact hours.

This activity was planned by and for the healthcare team, and learners will receive 4 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 4.8 hours for Alabama nurses.

AACN Synergy CERP Category B.

NetCE designates this activity for 4 hours ACPE credit(s). ACPE Universal Activity Numbers: JA4008164-0000-23-H04-P and JA4008164-0000-23-H04-T.

Social workers completing this intermediate-to-advanced course receive 4 Clinical continuing education credits.

NetCE designates this continuing education activity for 3 NBCC clock hours.

Individual State Nursing Approvals

In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 07/29/2025); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2025); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

Special Approvals

This course has been approved by the Nevada State Board of Nursing to meet the requirement for cultural competency education.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency, and California Assembly Bill 241, Implicit Bias.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to provide members of the interprofessional healthcare team with the knowledge, skills, and strategies necessary to provide culturally competent and responsive care to all patients.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define cultural competence, implicit bias, and related terminology.
2. Outline social determinants of health and barriers to providing care.
3. Discuss best practices for providing culturally competent care to various patient populations.
4. Discuss key aspects of creating a welcoming and safe environment, including avoidance of discriminatory language and behaviors.

Pharmacy Technician Learning Objectives

Upon completion of this course, you should be able to:

1. Identify cultural and social factors that impact the provision of health care.
2. Outline approaches to ensure that one provides patient-centered and culturally responsive care.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Culturally competent care has been defined as "care that takes into account issues related to diversity, marginalization, and vulnerability due to culture, race, gender, and sexual orientation" [1]. A culturally competent person is someone who is aware of how being different from the norm can be marginalizing and how this marginalization may affect seeking or receiving health care [1]. To be effective cross-culturally with any diverse group, healthcare professionals must have awareness, sensitivity, and knowledge about the culture involved, enhanced by the use of cross-cultural communication skills [2; 3].

Healthcare professionals are accustomed to working to promote the healthy physical and psychosocial development and well-being of individuals within the context of the greater community. For years, these same professionals have been identifying at-risk populations and developing programs or making referrals to resources to promote the health and safety of at-risk groups. But, because of general assumptions, persistent stereotypes, and implicit and explicit biases, culture-related healthcare disparities persist [2]. In the increasingly diverse landscape of the United States, assessing and addressing culture-related barriers to care are a necessary part of health care. This includes seeking to improve one's cultural competence and identifying blind spots and biases.

DEFINITIONS

CULTURAL COMPETENCE

In healthcare, cultural competence is broadly defined as practitioners' knowledge of and ability to apply cultural information and appreciation of a different group's cultural and belief systems to their work [4]. It is a dynamic process, meaning that there is no endpoint to the journey to becoming culturally aware, sensitive, and competent. Some have argued that cultural curiosity is a vital aspect of this approach.

CULTURAL HUMILITY

Cultural humility refers to an attitude of humbleness, acknowledging one's limitations in the cultural knowledge of groups. Practitioners who apply cultural humility readily concede that they are not experts in others' cultures and that there are aspects of culture and social experiences that they do not know. From this perspective, patients are considered teachers of the cultural norms, beliefs, and value systems of their group, while practitioners are the learners [5]. Cultural humility is a lifelong process involving reflexivity, self-evaluation, and self-critique [6].

DISCRIMINATION

Discrimination has traditionally been viewed as the outcome of prejudice [7]. It encompasses overt or hidden actions, behaviors, or practices of members in a dominant group against members of a subordinate group [8]. Discrimination has also been further categorized as lifetime, which consists of major discreet discriminatory events, or everyday, which is subtle, continual, and part of day-to-day life and can have a cumulate effect on individuals [9].

DIVERSITY

Diversity "encompasses differences in and among societal groups based on race, ethnicity, gender, age, physical/mental abilities, religion, sexual orientation, and other distinguishing characteristics" [10]. Diversity is often incorrectly conceptualized into singular dimensions as opposed to multiple and intersecting diversity factors [11].

INTERSECTIONALITY

Intersectionality is a term to describe the multiple facets of identity, including race, gender, sexual orientation, religion, sex, and age. These facets are not mutually exclusive, and the meanings that are ascribed to these identities are inter-related and interact to create a whole [12]. This term also encompasses the ways that different types and systems of oppression intersect and affect individuals.

PREJUDICE

Prejudice is a generally negative feeling, attitude, or stereotype against members of a group [13]. It is important not to equate prejudice and racism, although the two concepts are related. All humans have prejudices, but not all individuals are racist. The popular definition is that "prejudice plus power equals racism" [13]. Prejudice stems from the process of ascribing every member of a group with the same attributes [14].

RACISM

Racism is the "systematic subordination of members of targeted racial groups who have relatively little social power…by members of the agent racial group who have relatively more social power" [15]. Racism is perpetuated and reinforced by social values, norms, and institutions.

There is some controversy regarding whether unconscious (implicit) racism exists. Experts assert that images embedded in our unconscious are the result of socialization and personal observations, and negative attributes may be unconsciously applied to racial minority groups [16]. These implicit attributes affect individuals' thoughts and behaviors without a conscious awareness.

Structural racism refers to the laws, policies, and institutional norms and ideologies that systematically reinforce inequities, resulting in differential access to services such as health care, education, employment, and housing for racial and ethnic minorities [17; 18].

BIAS: IMPLICIT AND EXPLICIT

In a sociocultural context, biases are generally defined as negative evaluations of a particular social group relative to another group. Explicit biases are conscious, whereby an individual is fully aware of his/her attitudes and there may be intentional behaviors related to these attitudes [19]. For example, an individual may openly endorse a belief that women are weak and men are strong. This bias is fully conscious and is made explicitly known. The individual's ideas may then be reflected in his/her work as a manager.

FitzGerald and Hurst assert that there are cases in which implicit cognitive processes are involved in biases and conscious availability, controllability, and mental resources are not [20]. The term "implicit bias" refers to the unconscious attitudes and evaluations held by individuals. These individuals do not necessarily endorse the bias, but the embedded beliefs/attitudes can negatively affect their behaviors [21; 22; 23; 24]. Some have asserted that the cognitive processes that dictate implicit and explicit biases are separate and independent [24].

Implicit biases can start as early as 3 years of age. As children age, they may begin to become more egalitarian in what they explicitly endorse, but their implicit biases may not necessarily change in accordance to these outward expressions [25]. Because implicit biases occur on the subconscious or unconscious level, particular social attributes (e.g., skin color) can quietly and insidiously affect perceptions and behaviors [26]. According to Georgetown University's National Center on Cultural Competency, social characteristics that can trigger implicit biases include [27]:

- Age
- Disability
- Education
- English language proficiency and fluency
- Ethnicity
- Health status
- Disease/diagnosis (e.g., human immunodeficiency virus [HIV])
- Insurance
- Obesity
- Race
- Socioeconomic status
- Sexual orientation, gender identity, or gender expression
- Skin tone
- Substance use

An alternative way of conceptualizing implicit bias is that an unconscious evaluation is only negative if it has further adverse consequences on a group that is already disadvantaged or produces inequities [20; 28]. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages [28].

When the concept of implicit bias was introduced in the 1990s, it was thought that implicit biases could be directly linked to behavior. Despite the decades of empirical research, many questions, controversies, and debates remain about the dynamics and pathways of implicit biases [21].

Specific conditions or environmental risk factors have been associated with an increased risk for certain implicit biases, including [130; 131]:

- Stressful emotional states (e.g., anger, frustration)
- Uncertainty
- Low-effort cognitive processing
- Time pressure
- Lack of feedback
- Feeling behind with work
- Lack of guidance
- Long hours
- Overcrowding
- High-crises environments
- Mentally taxing tasks
- Juggling competing tasks

ROLE OF INTERPROFESSIONAL COLLABORATION AND PRACTICE

The study of implicit bias is appropriately interdisciplinary, representing social psychology, medicine, health psychology, neuroscience, counseling, mental health, gerontology, gender/sexuality studies, religious studies, and disability studies [28]. Therefore, implicit bias empirical research and curricula training development lends itself well to interprofessional collaboration and practice (ICP).

The main characteristics of ICP allow for implicit and explicit biases to be addressed by the interprofessional team. One of the core features of ICP is sharing—professionals from different disciplines share their philosophies, values, perspectives, data, and strategies for planning of interventions [29]. ICP also involves the sharing of roles, responsibilities, decision making, and power [30]. Everyone on the team employs their expertise, knowledge, and skills, working collectively on a shared, patient-centered goal or outcome [30; 31].

Another feature of ICP is interdependency. Instead of working in an autonomous manner, each team member's contributions are valued and maximized, which ultimately leads to synergy [29]. At the heart of this are two other key features: mutual trust/respect and communication [31]. In order to share responsibilities, the differing roles and expertise are respected.

Experts have recommended that a structural or critical theoretical perspective be integrated into core competencies in healthcare education to teach students about implicit bias, racism, and health disparities [32]. This includes [32]:

- Values/ethics: The ethical duty for health professionals to partner and collaborate to advocate for the elimination of policies that promote the perpetuation of implicit bias, racism, and health disparities among marginalized populations.

- Roles/responsibilities: One of the primary roles and responsibilities of health professionals is to analyze how institutional and organizational factors promote racism and implicit bias and how these factors contribute to health disparities. This analysis should extend to include one's own position in this structure.

- Interprofessional communication: Ongoing discussions of implicit bias, perspective taking, and counter-stereotypical dialogues should be woven into day-to-day practice with colleagues from diverse disciplines.

- Teams/teamwork: Health professionals should develop meaningful contacts with marginalized communities in order to better understand whom they are serving.

Adopting approaches from the fields of education, gender studies, sociology, psychology, and race/ethnic studies can help build curricula that represent a variety of disciplines [33]. Students can learn about and discuss implicit bias and its impact, not simply from a health outcomes perspective but holistically. Skills in problem-solving, communication, leadership, and teamwork should be included [33].

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. Healthy People 2030 groups social determinants of health into five categories [34]:

- Economic stability

- Education access and quality

- Health care access and quality

- Social and community context

- Neighborhood and built environment

These factors have a major impact on people's health, well-being, and quality of life. Examples of social determinants of health include [34]:

- Safe housing, transportation, and neighborhoods

- Racism, discrimination, and violence

- Education, job opportunities, and income

- Access to nutritious foods and physical activity opportunities

- Polluted air and water

- Language and literacy skills

Social determinants of health also contribute to wide health disparities and inequities. For example, people who lack access to grocery stores with healthy foods are less likely to have good nutrition, which raises the risk of heart disease, diabetes, and obesity and lowers life expectancy compared with those who have easier access to healthy foods [34].

Promoting healthy choices will not eliminate these and other health disparities. Instead, public health organizations and their partners must take action to improve the conditions in people's environments. Healthcare providers play a role by identifying factors affecting the health of their patients, providing resources (when appropriate), and advocating for healthy environments.

ECONOMIC STABILITY

In the United States, 1 in 10 people live in poverty, and many people are unable afford healthy foods, health care, and housing. People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or chronic conditions (e.g., arthritis) may be especially limited in their ability to work. In addition, many people with steady work still do not earn enough to afford the things they need to stay healthy [34].

Employment programs, career counseling, and high-quality childcare opportunities can help more people find and keep jobs. In addition, policies to help people pay for food, housing, health care, and education can reduce poverty and improve health and well-being [34].

HEALTH CARE ACCESS AND QUALITY

Many people in the United States are unable to access the healthcare services they need. About 1 in 10 people in the United States lack health insurance, and people without insurance are less likely to have a primary care provider and be able to afford the healthcare services and medications they need.

Strategies to increase insurance coverage rates are critical for making sure more people get important healthcare services, including preventive care and treatment for chronic illnesses [34].

In some cases, patients are not recommended health care services (e.g., cancer screenings) because they do not have a primary care provider or because they live too far away from healthcare providers who offer them. Interventions to increase access to healthcare professionals and improve communication—in person or remotely—can help more people get the care they need [34].

SOCIAL AND COMMUNITY CONTEXT

People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being. Many people face challenges and dangers they are not able to control, including unsafe neighborhoods, discrimination, or trouble affording the things they need. This can have a negative impact on health and safety throughout life.

Positive relationships at home, at work, and in the community can help reduce these negative impacts. But some people (e.g., children whose parents are in jail, adolescents who are bullied) often do not get support from loved ones or others. Interventions to help people access the social and community support they need are critical for improving health and well-being [34]. Healthy People 2030 objectives in this category focus on increasing the proportion of children and adolescents who have an adult they can talk to about serious problems, improving community health literacy, increasing the likelihood that an individual talks to friends or family about their health, and expanding access to online healthcare services [34].

BARRIERS TO PROVIDING CARE

Culturally diverse patients experience a variety of barriers when seeking health and mental health care, including:

- Immigration status
- Lower socioeconomic status
- Language barriers
- Cultural differences
- Lack of or poor health insurance coverage
- Fear of or experiences with provider discrimination
- Mistrust of healthcare systems

Such obstacles can interfere with or prevent access to treatment and services, compromise appropriate referrals, affect compliance with recommendations, and result in poor outcomes. Culturally competent providers build and maintain rich referral resources to meet patients' assorted needs.

Encountering discrimination when seeking health or mental health services is a barrier to optimal care and contributor to poorer outcomes in under-represented groups. Some providers will not treat patients because of moral objections, which can affect all groups, but particularly those who are gender and/or sexual minorities, religious minorities, and/or immigrants. In fact, in 2016, Mississippi and Tennessee passed laws allowing health providers to refuse to provide services if doing so would violate their religious beliefs [35]. However, it is important to remember that providers are obligated to act within their profession's code of ethics and to ensure patients receive the best possible care.

BEST PRACTICES FOR CULTURALLY RESPONSIVE CARE

The U.S. Department of Health and Human Services has outlined steps important to incorporate in evaluation and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills [36].

The first step is to engage patients. In nonemergent situations, it is important to establish rapport before asking a series of assessment questions or delving deeply into history taking. Providers should use simple gestures as culturally appropriate (e.g., handshakes, facial expressions, greetings) to help establish a first impression. The intent is that all patients feel understood and seen following each interaction. Culturally responsive interview behaviors and paperwork should be used at all times [36].

When engaging in any patient teaching, remember that individuals may be new to the specific language or jargon and expectations of the diagnosis and care process. Patients should be encouraged to collaborate in every step of their care. This consists of seeking the patient's input and interpretation and establishing ways they can seek clarification. Patient feedback can then be used to help identify cultural issues and specific needs. If appropriate, collaboration should extend to include family and community members.

Assessment should incorporate culturally relevant themes in order to more fully understand patients and identify their cultural strengths and challenges. Themes include [36]:

- Immigration history
- Cultural identity and acculturation
- Membership in a subculture
- Beliefs about health, healing, and help-seeking
- Trauma and loss

In some cases, it may be appropriate and beneficial to obtain culturally relevant collateral information, with the patient's permission, from sources other than the patient (e.g., family or community members) to better understand beliefs and practices that shape the patient's cultural identity and understanding of the world.

Practitioners should work to identify screening and assessment tools that have been translated into or adapted for other languages and have been validated for their particular population group(s). An instrument's cultural applicability to the population being served should be assessed, keeping in mind that research is limited on the cross-cultural applicability of specific test items or questions, diagnostic criteria, and concepts in evaluative and diagnostic processes [36].

Typically, culturally responsive care establishes holistic treatment goals that include objectives to improve physical health and spiritual strength; utilizes strengths-based strategies that fortify cultural heritage, identity, and resiliency; and recognizes that treatment planning is a dynamic process that evolves along with an understanding of patient history and treatment needs.

In addition to these general approaches, specific considerations may be appropriate for specific populations. While discussion of every possible patient subgroup is outside of the scope of this course, some of the most common factors are outlined in the following sections [36].

RACIAL BACKGROUNDS

Race and color impact the ways in which individuals interact with their environments and are perceived and treated by others. Race is defined as groups of humans divided on the basis of inherited physical and behavioral differences. As part of the cultural competence process and as a reflection of cultural humility, practitioners should strive to learn as much as possible about the specific racial/ethnic populations they serve [37]. However, considerable diversity exists within any specific culture, race,

or ethnicity [37]. Cultural beliefs, traditions, and practices change over time, both through generations and within an individual's lifetime. It is also possible for the differences between two members of the same racial/ethnic group to be greater than the differences between two people from different racial/ethnic groups. Within-group variations in how persons interact with their environments and specific social contexts are also often present.

As with all patients, it is vital to actively listen and critically evaluate patient relationships. All practitioners should seek to educate themselves regarding the experiences of patients who are members of a community that differs from their own. Resources and opportunities to collaborate may be available from community organizations and leaders.

Finally, preferred language and immigration/migration status should be considered. Interpreters should be used when appropriate, with adherence to best practices for the use of interpretation services. Stressing confidentiality and privacy is particularly important for undocumented workers or recent immigrants, who may be fearful of deportation.

Black Patients

"Black" or "African American" is a classification that serves as a descriptor; it has sociopolitical and self-identification ramifications. The U.S. Census Bureau defines African Americans or Black Americans as persons "having origins in any of the Black racial groups of Africa" [38].

According to the U.S. Census, African Americans number 46.9 million as of 2020 [39]. By 2060, it is projected they will comprise 17.9% of the U.S. population [40]. This group tends to be young; 30% of the African American population in the United States is younger than 18 years of age. In 2019, the median age for this group was 35 years [41]. In terms of educational attainment, 89.4% of African Americans 25 years of age or older had a high school diploma or completed college in 2020 [39]. Texas has the largest African American population, at 3.9 million [41].

Historical adversity and institutional racism contribute to health disparities in this group. For the Black population, patient assessment and treatment planning should be framed in a context that recognizes the totality of life experiences faced by patients. In many cases, particularly in the provision of mental health care, equality is sought in the provider-patient relationship, with less distance and more disclosing. Practitioners should assess whether their practices connect with core values of Black culture, such as family, kinship, community, and spirituality. Generalized or Eurocentric treatment approaches may not easily align with these components of the Black community [42]. Providers should also consider the impact of racial discrimination on health and mental health among Black patients. Reports indicate that expressions of emotion by Black patients tend to be negatively misunderstood or dismissed; this reflects implicit or explicit biases.

E B
EVIDENCE-BASED PRACTICE RECOMMENDATION

When providing mental health services for African Americans, the American Psychiatric Association recommends exploring how a patient's present experiences connect to historical trauma for a particular group or community.

(https://www.psychiatry.org/psychiatrists/diversity/education/stress-and-trauma/african-americans. Last accessed September 26, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

Asian Patients

As of 2019, 22.9 million Americans identified as Asian [43]. Between 2000 and 2019, Asians experienced the greatest growth compared with any other racial group at 81% [44; 45]. The Chinese group represents the largest Asian subgroup in the United States, and it is projected that this population will grow to 35.7 million between 2015 and 2040 [46; 47]. In 2019, Chinese Americans (excluding Taiwanese Americans) numbered at 5.2 million [43]. They also have the highest educational attainment; 54.6% of Asians 25 years of age or older had a bachelor's degree or higher in 2019 [43].

"Asian" is a single term widely used to describe individuals who have kinship and identity ties to Asia, including the Far East, Southeast Asia, and the Indian subcontinent [48]. This encompasses countries such as China, Japan, Korea, Vietnam, Cambodia, Thailand, India, Pakistan, and the Philippines. Pacific Islander is often combined with Asian American in census data. The Pacific Islands include Hawaii, Guam, Samoa, Fiji, and many others [48]. There are more than 25 Asian/Pacific Islander groups, each with a different migration history and widely varying sociopolitical environments in their homelands [49].

Asian American groups have differing levels of acculturation, lengths of residency in the United States, languages, English-speaking proficiency, education attainment, socioeconomic statuses, and religions. For example, there are approximately 32 different languages spoken among Asian Americans, and within each Asian subgroup (e.g., Chinese), multiple dialects may be present [49; 50]. In 2019, California had the largest Asian American population, totaling 5.9 million [44].

Recommended best practices when caring for Asian American patients include:

- Create an advisory committee using representatives from the community.
- Incorporate cultural knowledge and maintain flexible attitudes.
- Provide services in the patients' primary language.
- Develop culturally specific questionnaires for intake to capture information that may be missed by standard questionnaires.
- Emphasize traditional values and incorporate traditional practices (e.g., acupuncture) into treatment plans, when appropriate and desired.
- Explore patient coping mechanisms that draw upon cultural strengths.

Latino/a/x or Hispanic Patients

In 2020, the Hispanic population in the United States numbered 60.6 million [51]. The majority of the Hispanic population in the United States (63.3%) identify themselves as being of Mexican descent [53]. Approximately 27% of the U.S. Hispanic population identify as Puerto Rican, Cuban, Salvadoran, Dominican, Guatemalan, Colombian, Honduran, Ecuadorian, or Peruvian [54].

In 2020, the Hispanic population comprised 18.7% of the U.S. population [51]. As such, they are the largest ethnic minority group in the United States. By 2060, Hispanics are expected to represent 31% of the U.S. population [55]. They are also a young group, with a median age of 29.8 years [51]. In 2019, the three states with the largest Hispanic population growth were Texas (2 million), California (1.5 million), and Florida (1.4 million); these three states have the largest Hispanic populations overall [52].

When involved in the care of Latinx/Hispanic individuals, practitioners should strive to employ *personalismo* (warm, genuine communication) and recognize the importance of *familismo* (the centrality of the family). More flexible scheduling strategies may be more successful with this group, if possible, and some patients may benefit from culturally specific treatment and ethnic and gender matching with providers. Aspects of Latino culture can be assets in treatment: strength, perseverance, flexibility, and an ability to survive.

Native American Patients

The Native American population is extremely diverse. According to the U.S. Census, the terms "Native American," "American Indian," or "Alaskan Native" refer to individuals who identify themselves with tribal attachment to indigenous groups of North and South America [56]. In the United States, there are 574 federally recognized tribal governments and 324 federally recognized reservations [57].

In 2020, it was reported that there were 7.1 million Native Americans in the United States, which is approximately 2% of the U.S. population [57]. By 2060, this number is projected to increase to 10.1 million, or 2.5% of the total population [57].

In general, this group is young, with a median age of 31 years, compared with the general median age of 37.9 years [58]. As of 2018, the states with the greatest number of residents identifying as Native American are Alaska, Oklahoma, New Mexico, South Dakota, and Montana [59]. In 2016, this group had the highest poverty rate (26.2%) of any racial/ethnic group [58].

Listening is an important aspect of rapport building with Native American patients, and practitioners should use active listening and reflective responses. Assessments and histories may include information regarding patients' stories, experiences, dreams, and rituals and their relevance. Interruptions and excessive questioning should be avoided if at all possible. Extended periods of silence may occur, and time should be allowed for patients to adjust and process information. Practitioners should avoid asking about family or personal matters unrelated to presenting issues without first asking permission to inquire about these areas. Native American patients often respond best when they are given suggestions and options rather than directions.

E B

EVIDENCE-BASED PRACTICE RECOMMENDATION

The American Psychological Association recommends that clinicians aim to understand and encourage Indigenous/ethnocultural sources of healing within professional practice.

(https://www.apa.org/about/policy/guidelines-race-ethnicity.pdf. Last accessed September 26, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

White American Patients

In 2021, 76.3% of the U.S. population identified as White alone [60]. The U.S. Census Bureau defines White race as person having origins in any of the original peoples of Europe, the Middle East, or North Africa [38]. While the proportion of population identifying as White only has decreased between 2010 and 2020, the numbers of persons identifying as White and another race/ethnicity increased significantly. The White population in the United States is diverse in its religious, cultural, and

social composition. The greatest proportion of this group reports a German ancestry (17%), followed by Irish (13%), English (10%), and Italian (7%) [61].

Providers can assume that most well-accepted treatment approaches and interventions have been tested and evaluated with White American individuals, particularly men. However, approaches may need modification to suit class, ethnic, religious, and other factors.

Providers should establish not only the patient's ethnic background, but also how strongly the person identifies with that background. It is also important to be sensitive to persons multiracial/multiethnic heritage, if present, and how this might affect their family relationships and social experiences. Assumption of White race should be avoided, as White-passing persons of color have their own unique needs.

Multiracial Patients

Racial labels do not always have clear meaning in other parts of the world; how one's race is defined can change according to one's current environment or society. A person viewed as Black in the United States can possibly be viewed as White in Africa. Racial categories also do not easily account for the complexity of multiracial identities. An estimated 3% of United States residents (9 million individuals) indicated in the 2010 Census that they are of more than one race [149]. The percentage of the total United States population who identify as being of mixed race is expected to grow significantly in coming years, and some estimate that it will rise as high as one in five individuals by 2050 [36; 150].

Multiracial individuals often report feeling not fully embraced by any racial or ethnic group, and mistaken identity is a common issue. A small study of multiracial patients assessed their healthcare experiences and noted six commonly encountered microaggressions: mistaken identity, mistaken relationships, fixed forms, entitled examiner, pervasive stereotypes, and intersectionality [144]. It is important to avoid assuming race/culture based only on appearance and to take into account the patient's self-reported identity.

RELIGIOUS, CULTURAL, AND ETHNIC BACKGROUNDS

Religion, culture, beliefs, and ethnic customs can influence how patients understand health concepts, how they take care of their health, and how they make decisions related to their health. Without proper training, clinicians may deliver medical advice without understanding how health beliefs and cultural practices influence the way that advice is received. Asking about patients' religions, cultures, and ethnic customs can help clinicians engage patients so that, together, they can devise treatment plans that are consistent with the patients' values [37].

Respectfully ask patients about their health beliefs and customs and note their responses in their medical records. Address patients' cultural values specifically in the context of their health care. For example, one may ask [37]:

- "Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?"

- "Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight?"

- "Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to talk to about your condition?"

- "What do you call your illness and what do you think caused it?"

- "Do any traditional healers advise you about your health?"

Practitioners should avoid stereotyping based on religious or cultural background. Each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Asking patients about their beliefs and way of life is the best way to be sure you know how their values may impact their care [37].

The following sections provide a glimpse of the beliefs and practices of the major world religions. This overview is meant only to give a very simple, brief summary of the general ideology of each religion. By no means are all of the rites or beliefs described practiced by all members of each religion; likewise, not all religious rites or beliefs are discussed for each religion. As always, individualized assessment is encouraged.

Judaism

Judaism emerged in the Southern Levant (an area in the Middle East) in about 2000 B.C.E. [136]. There are approximately 13 million Jewish people in the world—6 million in North America, 4.3 million in Asia, and 2.5 million in Europe [137]. Jewish descent is traced through the maternal line, but the choice to practice Judaism is made by the individual. In Jewish tradition, the Torah is believed to be the word of God and the ultimate authority.

There are three tenets of Judaism. The first tenet is monotheism; there is one God who created the universe and continues to rule [138]. The second tenet is that the Jews were chosen to receive the law of God (Yahweh) and to serve as role models for humankind [138]. The third tenet refers to the covenant, which is a contractual agreement between God and the Jewish people. According to the agreement, they will be rewarded if they obey God and keep his commandments; failing to do so would result in divine retribution. Also, they believe that studying the Torah and faithfulness to God and his commandments may hasten the arrival of the Messiah [136; 138].

Jewish law focuses on dietary practices, the Sabbath, and annual holidays or festivals. Observing the dietary laws is called keeping kosher. One's home is considered the table of the Lord, and therefore certain animals considered unclean (e.g., pork, shellfish) are not to be eaten. However, animals with split hooves and animals that chew their cud are acceptable. Acceptable animals must be slaughtered correctly, must have the blood drained from them, and must not be served with dairy products. Those who adhere to kosher laws have separate sets of dishes and utensils for preparing and serving meat, dairy

products, and Passover meals [138; 139]. Passover, Rosh Hashanah, and Yom Kippur are major festivals observed by members of the faith.

Christianity

Christianity emerged in the 1st century C.E. It is the largest religion in North America, and there are approximately 2 billion followers worldwide [136]. There are three major divisions in Christianity: Roman Catholicism, Eastern Orthodoxy, and Protestantism [136; 138]. Christianity is based on the life and teachings of Jesus Christ, and followers believe that salvation and eternal life can be obtained through their belief in Jesus [137]. The concept of the Trinity is also basic to Christian belief. Although God is perceived as one, God is also expressed in three roles: Father (Creator), Son (Redeemer), and the Holy Spirit (Sustainer) [138; 139].

Baptism and the Eucharist or Holy Communion are the primary sacraments celebrated in most Christian churches [138]. Baptism symbolizes the forgiveness of sins, new life, and initiation into the Christian church. During the baptism, persons are either immersed in water or water is sprinkled or poured over them. Eucharist or Holy Communion is a ritual meal in which bread and wine are taken in remembrance of the body and blood of Jesus that was broken and shed at the cross [136]. Major Christian holidays include Easter (commemorating the death and resurrection of Jesus Christ) and Christmas (celebrating the birth of Jesus).

Christians consider the Bible to be the word of God. It is composed of 66 to 81 separate books (depending on denomination). Christians hold various perspectives on the nature, purpose, and approaches to the interpretation of the Bible.

Islam

Islam is the fastest-growing religion in the United States and throughout the world [140]. Members of Islam are called Muslims, and approximately 3.45 million live in the United States [140]. Islam began in Arabia around 570–632 C.E. and was founded by the prophet Muhammad. It is a monotheistic religion whose followers believe there is one God and that Muhammad was his last Prophet. They believe

the Qur'an (or Koran) is the literal word of God (or Allah in Arabic) that was revealed to Muhammad and mediated by Gabriel, the angel of revelation [138]. Arabic is the language used in Islamic prayer/liturgy [137]. Major festivals or holidays include Al-Hijra, Milad un Nabi, Ramadan, Eid al-Fitr, Eid al-Adha, Day of Ashura, and Laylatul Qadr.

Most Muslims are of one of two denominations: Sunni and Shia. While various denominations may have slightly different beliefs or translations, Islam has six major doctrines. The first is the belief in divine unity, or tawhid [136; 138]. The second is the belief in angels as agents of God. Angels have many functions, such as carrying messages to prophets and watching over and keeping track of people. The third is a belief in prophecy as revealed in the Qur'an. The fourth involves belief in scripture (Qur'an), and the fifth is the belief in Judgment Day and life after death [136; 138]. On the Last Day (or final judgment), both the living and the dead will be judged. The faithful will be rewarded, and the unfaithful will be cast into hell. Finally, the sixth doctrine is the Divine Decree and Predestination. It suggests that Allah has already determined who will receive eternal salvation [136; 138].

The Five Pillars are the core beliefs and practices of Islam. The first is the Shahada (profession of faith)—the belief that there is no god but Allah, and Muhammad is his messenger [136]. The second pillar is the Salat (ritual prayer). Muslims pray facing Mecca five times every day: at dawn, noon, mid-afternoon, sunset, and evening [138]. The prayers are usually performed on a rug or mat specifically for this purpose. Zakat (almsgiving) is the third pillar of Islam. Muslims are expected to donate a certain portion of their income to community members in need [138]. Sawm (or fasting) is the fourth pillar of Islam. During the daylight hours of Ramadan, healthy adult Muslims are expected to abstain from food, drink, and sexual relations. This is a time of reflecting, renewing faith, and being grateful for everything Allah has given [138]. The fifth pillar of Islam is Hajj (pilgrimage). After 16 years of age, every Muslim in good health and whose finances permit is expected to visit the holy city of Mecca, located in present-day Saudi Arabia.

Hinduism

Hinduism is one of the world's oldest religions, dating back to about 1500 B.C.E. [138]. Unlike other major religions, it was not founded by a single person but was born of many religious beliefs and philosophies [138]. Hinduism originated in India, and today it is the third-largest religion in the world. There are approximately 1.1 billion adherents worldwide and 2.3 million adherents in the United States [141]. Hinduism is a polytheistic religion with three major deities: Shiva, Vishnu, and Brahma [138]. There are many sacred texts in Hinduism, including The Ramayana, an epic tale of Lord Rama's victory over the 10-headed demon Ravana, and The Mahabharata, the world's longest epic poem that is an historical account of the birth of Hinduism along with a code of ethics for the faithful [136]. Major Hindu festivals include Makar Sankranti, Holi, Diwali, Mahashivratri, Vasant Panchami, Rama Navami, and Janmashtami/Krishna Jayanti.

Two concepts are central to Hinduism: karma and reincarnation. Karma refers to the spiritual principle of cause and effect. In short, people's circumstances are the result of present and past-life actions of good or evil [136]. Hindus also believe in the continuous cycle of life, death, and rebirth (reincarnation) that continues until the soul "transcends all pain and pleasure and release itself from all fears and attachments" [138]. This state is called samsara or transmigration [138].

The Hindu temple is a cultural center where people come to sing, read sacred texts, and perform rituals [136]. The chanting of mantra called pathas is a traditional Hindu practice and is believed to have transformative power. Puja or daily worship is an important aspect of Hinduism. It entails the offering of food, incense, flowers, fruits, ashes, and other articles to an image of a deity [138]. Tirthas refer to pilgrimage sites and holy places in Hinduism [138].

Buddhism

There are approximately 3 million Buddhists in the United States and about 488 million worldwide [141]. Buddhism was founded in northeastern India by Siddhartha Gautam, whose name was later changed to the Buddha or Enlightened One.

At 29 years of age, the Buddha sought knowledge from several forest yogis and learned meditation techniques. After six years, Buddhists believe Gautama found enlightenment while meditating under a Bodhi tree and was released from the cycle of rebirths [138]. He began promoting the idea of a middle path that focused on purity of thought and deed. Buddha believed awareness was the path to overcoming death [136]. He did not want to be worshiped as a god or savior. Instead, he believed his role was to help people find their path to freedom and enlightenment.

The Four Noble Truths and the Eightfold Path are essential to understanding Buddhism. The Four Noble Truths have been identified as the first teaching given by Buddha [137]:

- There is suffering in life.
- Human desire is the cause of suffering.
- The end of human suffering is possible.
- The Eightfold Path is how one achieves nirvana.

Collectively, the Four Noble Truths explain why humans suffer and how to overcome suffering. Within the Four Noble Truths is found the Eightfold Path. Wangu describes the Eightfold Path as consisting of the right opinion, right intentions, right speech, right conduct, right livelihood, right effort, right mindfulness, and right concentration [138]. These eight paths are grouped into three key elements of Buddhist practice: morality, wisdom, and concentration [138].

Buddhists engage in rituals such as chanting and placing flowers, candles, and incense before an image of Buddha. Buddhists celebrate many holidays and festivals, most of which commemorate important events in the life of the Buddha. Every year, Buddhists celebrate Vesak, a festival that commemorates Buddha's birth, enlightenment, and death. During each quarter of the moon, followers of Buddhism participate in a ceremony called Uposatha [136]. This observance allows Buddhists to renew their commitment to their teachings. Buddhist New Year is a time for reflection of past lives and identifying and rectifying mistakes [136].

Confucianism

Confucianism is described as a way of life, philosophy, religion, or ethical code by which to live [138]. It was developed from the teachings of Confucius, who was born around 551 B.C.E. [138]. These teachings focus on good conduct, wisdom, and proper social relationships. Confucius has had a great influence on Chinese culture. Although temples were built to honor him, he is not perceived as a god. The temples are used for public ceremonies only and not as places of worship [138].

Confucianism advocates eight key concepts. The first is Jen, which translates as love, human-heartedness, and goodness [138]. The second concept is Chun-tzu, which refers to a state of centeredness whereby one exhibits Confucians' values effortlessly and without the need for self-monitoring. The third concept is Li, or a sense of order in one's life that coincides with social convention. The fourth concept is Te, or the appropriate use of power by leaders and authority figures. The fifth concept is Wen, which refers to the cultural arts (e.g., music, drama, poetry) that help to maintain unity in society [138]. The remaining concepts are Chi (the wisdom of proper action), Hsin (integrity), and Yi (righteousness or justice).

Taoism

Taoism (pronounced DOW-ism) is a Chinese philosophy and religion dating back to the fourth century B.C.E. [136]. Tao means "the way," and it has no founder or central figures. Taoists do not worship a god. Instead, they focus on coming into harmony with Tao, the cosmic energy that blows through everything. Taoism emphasizes what is natural and going with the flow of life. Today, there are about 20 million Taoists, and most followers live in China, Taiwan, or Southeast Asia [136].

Meditation is an important practice, and the goal of meditation is to come into harmony with the universe [136]. The philosophy is found in a text, the *Tao-te-Ching (Classic Way and Its Power)*, dating back to the third century B.C.E. and attributed to Lao Tzu [138].

Shintoism

Shintoism began during prehistoric times on the Japanese islands [138]. Today, Shinto is the religion of Japan, and it has approximately 112 million followers; more than 75% of them follow Buddhism as well [138]. Like Taoism, Shinto has no founder or central figure. It teaches that all things in the world are imbued with a spirit (kami). Therefore, Shinto followers revere nature in all forms [138].

Most of the deities associated with Shinto are related to nature, such as the sky, earth, heavenly bodies, and storms [136]. However, deities are not different from humans, because everything is imbued with spirit. Everything is connected, including rocks, trees, dust, water, animals, and humans [138].

Shinto has no fixed doctrine and no scripture or sacred text. However, ancient prayers are passed down via oral tradition. Shinto followers worship primarily individually rather than in groups, and followers engage in purification rituals (e.g., handwashing) [138]. Worship occurs outside the shrine, and worshipers usually bring offerings of food or coins for the spirit (kami). These offerings are not given as sacrifices but as signs of gratitude [138]. Some followers write prayers on slips of paper and leave them nearby.

New Age Spirituality

The New Age movement became popular in Western society in the 1970s [142]. The precise definition of the term differs among scholars largely due to its highly eclectic range of spiritual beliefs and practices [142; 143]. The movement takes many shapes and is continually changing. However, there are some common features that distinguish it from other religions, such as followers who [136]:

- Look forward to a society that reunites the wisdom of both science and religion
- Adopt holistic and alternative healing methods
- Embrace a wide array of traditional and nontraditional spiritual beliefs and practices
- Accept the existence of a universal energy that undergirds and permeates all of existence

Adherents believe healing can occur when individuals connect with this universal energy and learn to use it. This energy has been called by many names by different cultures, including *chi* (Chinese), *ki* (Japanese), *prana* (Sanskrit), *mana* (Pacific Islander), or the use of self as a final authority [136].

GENDER

Gender identity is a vital aspect of a person's experience of the world and of themselves. It also impacts the ways in which the world perceives and treats individuals, with a clear effect on the effective provision of health and mental health care. This section will focus on persons presenting as cisgender male or female; special considerations for those who are transgender, non-binary, or gender nonconforming will be explored in the next section.

An increasing amount of research is supporting a relationship between men's risk for disease and death and male gender identity, and the traditional male role has been shown to conflict with the fostering of healthy behaviors [62; 63]. Male gender identity is related to a tendency to take risks, and the predilection for risky behavior begins in boyhood [63; 64; 65]. In addition, boys are taught that they should be self-reliant and independent and should control their emotions, and societal norms for both boys and men dictate that they maintain a strong image by denying pain and weakness [62; 64; 65].

Issues related to male gender identity have several important implications for health. First, risky behavior is associated with increased morbidity and mortality. Second, the concept of masculinity leads to inadequate help- and information-seeking behavior and a reduced likelihood to engage in behavior to promote health [62; 64; 65]. These behaviors appear to be rooted in a decreased likelihood for men to perceive themselves as being ill or at risk for illness, injury, or death [62]. Third, male gender identity, coupled with lower rates of health literacy, creates special challenges for effectively communicating

health messages to men [66; 67; 68]. Gender differences in health-related behaviors are consistent across racial/ethnic populations, although specific behaviors vary according to race/ethnicity [63].

Men's beliefs about masculinity and traditional male roles affect health communication, and healthcare practitioners should consider male-specific beliefs and perceptions when communicating with male patients. For example, because men tend to focus on present rather than future health, concepts of fear, wellness, and longevity often do not work well in health messages [69]. Instead, healthcare practitioners should focus more on "masculine" concepts, such as strength, safety, and performance, all of which tie into men's perceptions of their roles as providers and protectors.

Although men are more likely than women to lack a regular healthcare provider and to avoid seeking help or information, women are more likely to have a chronic condition requiring regular monitoring and are more likely to have forgone necessary health care due to the cost [70]. In general, women are disproportionately affected by stresses related to caregiving, and this can be a barrier to help-seeking. Caregiving has been socialized as a feminine role, and two out of every three caregivers in the United States are women, meaning they provide daily or regular support to children, adults, or people with chronic illnesses or disabilities [145]. Women who are caregivers have a greater risk for poor physical and mental health, including depression and anxiety.

Women are more likely than men to be diagnosed with a mental health disorder, and more than 20% of women in the United States experienced a mental health condition in the past year [146]. In addition to being disproportionately affected, mental health conditions, such as depression and bipolar disorder, can manifest differently in or have different impacts on women than men. Much of the research into women's health has focused on the perinatal period, which limits our knowledge of how mental illness affects women's lives.

There is also some evidence that women's pain is less likely to be taken seriously and controlled than male patients. A series of four studies found a relative gender-pain exaggeration bias, wherein perceivers believe women, relative to men, to be emotionally dramatizing and therefore more likely to exaggerate versus downplay their pain [147]. This bias may lead perceivers to interpret women's, relative to men's, pain reports as overstatements, inauthentic, or dramatized.

Providing gender-sensitive care to women involves overcoming the limitations imposed by the dominant medical model in women's health. This requires theoretical bases that do not reduce women's health and illness experience into a disease. This philosophy incorporates explanations of health and empowers women to effectively and adequately deal with their situations. The major components incorporated into the development of sensitive care include:

- Gender is a central feature.
- Women's own voices and experiences are reflected.
- Diversities and complexities are incorporated into women's experiences.
- Theorists reflect about underlying androcentric and ethnocentric assumptions.
- Sociopolitical contexts and constraints of women's experiences are considered.
- Guidelines for practice with specific groups of women are provided.

GENDER AND SEXUAL MINORITIES

The gender and sexual minority (GSM) population is a diverse group that can be defined as a subculture. It includes homosexual men, lesbian women, bisexual persons, transgender individuals, and those questioning their sexual identity, among others. The GSM population is diverse, representing all ages and all socioeconomic, ethnic, educational, and religious backgrounds. The population has been described as "hidden and invisible," "marginalized," and "stigmatized." As a result, the unique health and safety needs of the population have often been overlooked

or ignored. Clear definitions of the concepts related to sexual identity will be helpful. The following is a glossary of terms used in discussions of this group [71; 72; 73; 74; 75; 76]:

Asexual/aromantic: An individual who does not experience sexual attraction. There is considerable diversity in individuals' desire (or lack thereof) for romantic or other relationships.

Bisexual: An adjective that refers to people who relate sexually and affectionately to both women and men.

Coming-out process: A process by which an individual, in the face of societal stigma, moves from denial to acknowledging his/her sexual orientation. Successful resolution leads to self-acceptance. Coming out is a lifelong process for lesbian, gay, bisexual, and transgender persons and their families and friends as they begin to tell others at work, in school, at church, and in their communities.

Gay: The umbrella term for GSM persons, although it most specifically refers to men who are attracted to and love men. It is equally acceptable and more accurate to refer to gay women as "lesbians."

Gender and sexual minorities (GSM): A term meant to encompass lesbian, gay, bisexual, trans, queer/questioning, intersex/intergender, asexual/ally (LGBTQIA) people as well as less well-recognized groups, including aromantic, two-spirited, and gender-fluid persons.

Heterosexism: An institutional and societal reinforcement of heterosexuality as the privileged and powerful norm.

Heterosexuality: Erotic feelings, attitudes, values, attraction, arousal, and/or physical contact with partners of the opposite gender.

Homophobia: A negative attitude or fear of non-straight sexuality or GSM individuals. This may be internalized in the form of negative feelings toward oneself and self-hatred. Called "internalized homophobia," it may be manifested by fear of discovery, denial, or discomfort with being LGBTQIA, low self-esteem, or aggression against other lesbians and gay men.

Homosexuality: The "persistent sexual and emotional attraction to members of one's own gender" as part of the continuum of sexual expression. Typically not used to describe people.

LGBTQIA: An acronym used to refer to the lesbian, gay, bisexual, transgender/transsexual, queer/questioning, intersex/intergender, asexual/ally community. In some cases, the acronym may be shortened for ease of use or lengthened for inclusivity. Members of this group may also be referred to as gender and sexual minorities (GSM).

Queer: An umbrella term to describe persons with a spectrum of identities and orientations that are outside of the heteronormative standard.

Sexual identity: The inner sense of oneself as a sexual being, including how one identifies in terms of gender and sexual orientation.

Sexual orientation: An enduring emotional, romantic, sexual, and/or affectionate attraction to another person. Individuals may experience this attraction to someone of the same gender, the opposite gender, both genders, or gender nonconforming.

Transgender: An umbrella term describing a number of distinct gender positions and identities including: crossdressing, transsexual, nonbinary, and intersex.

One's intrapersonal acceptance or rejection of societal stereotypes and prejudices, the acceptance of one's self-identity as a sexual minority, and how much one affiliates with other members of the GSM community varies greatly among individuals [77]. Some authors stress the diversity within the GSM community by discussing "GSM populations" [78]. For example, it is understandable that a GSM population living in rural areas of the United States would have little in common with a GSM population living in urban areas or "gay-friendly" neighborhoods. Additionally, mental health experts have suggested that "GSM community" symbolizes a single group of individuals who express their sexuality differently than the majority of heterosexual individuals. However, many distinct communities have been identified, including lesbian, gay, bisexual, and transgender [79]. Each community is different from

the other as well as different from the heterosexual community. A culturally competent healthcare provider should keep this diversity in mind so that vital differences among these smaller groups are not lost when thinking of the GSM population in general.

Commonalities exist among the GSM communities as well. For example, many adolescents, whether gay, lesbian, bisexual, transgender, or questioning their sexual identity, lack sexual minority role models to assist with successful psychosocial development [79].

The subtle and pervasive ways that discomfort with GSM individuals may be manifested have been examined and, in some instances, categorized as "cultural heterosexism," which is characterized by the stigmatization in thinking and actions found in our nation's cultural institutions, such as the educational and legal systems [80]. "Cultural heterosexism fosters individual antigay attitudes by providing a ready-made system of values and stereotypical beliefs that justify such prejudice as natural" [81]. Perhaps the paucity of information about the GSM community in basic professional education has been a reflection of cultural heterosexism. Writers, funding sources, and publishers have been exposed to the same cultural institutions for many years.

Individuals generally begin to absorb these institutional attitudes as children and may consequently develop "psychologic heterosexism," which may also manifest as antigay prejudice. Many individuals, as children, have little contact with someone who is openly gay and, as a result, may not be able to associate homosexuality with an actual person. Instead, they may associate it with concepts such as "sin," "sickness," "predator," "outsider," or some other negative characteristic from which the individual wants to maintain distance [81]. Psychologic heterosexism involves (among other factors) considering sexual identity and determining that one does not want to think further about it. The direction of this thinking is undeniably negative, resulting in an environment that allows antigay hostility [81]. The impact of antigay prejudice on the physical and mental health of members of the LGBTQIA community and their families should not be underestimated [82; 83].

Sexual minority individuals also are not immune to societal attitudes and may internalize negative aspects of the antigay prejudice experience. Anxiety, depression, social withdrawal, and other reactions may result [2; 84]. While the study of psychologic heterosexism, both blatant and subtle, is in the early stages of research, it has had a measurable impact on the mental health of the GSM community [85; 86; 87; 88].

Examples of the range of manifestations of heterosexism and/or homophobia in our society are readily available. Without difficulty, each example presented here may be conceptualized as related to the emotional or physical health of a GSM individual or family member:

- A kindergarten student calls another child an LGBTQ+ slur but does not really know what he is saying.

- A teenage girl allows herself to become pregnant, "proving" her heterosexuality to herself, her family, and her friends.

- A parent worries that her 12-year-old daughter is still a "tomboy."

- An office employee decides to place a photo of an old boyfriend in her office rather than a photo of her gender-nonconforming partner of five years.

- A college student buries himself in his studies in an effort to ignore his same-sex feelings and replace feelings of isolation.

- Two teenage girls, thought by peers to be transgender individuals, are assaulted and killed while sitting together in an automobile.

- A female patient is told by a healthcare provider that her haircut makes her look like a lesbian and is examined roughly.

- A gay man chooses not to reveal his sexual identity to his healthcare provider out of fear of a reduction or withdrawal of healthcare services.

The manifestations of heterosexism have inhibited our learning about the LGBTQIA population and its needs [78]. Gay patients have feared open discussion about their health needs because of potential negative reactions to their self-disclosure. Prejudice has impacted research efforts by limiting available funding [77]. All of these factors emphasize that the healthcare education system has failed to educate providers and researchers about the unique aspects of LGBTQIA health [83; 89].

Common Myths

Many myths surround homosexuality; a few are outlined below. The origin of these myths may be better understood after examining the history of homosexuality as well as the attitudes toward human sexuality in general. The history of the development of societal norms related to homosexuality includes misconceptions developed during times when research was not available on which to build a scientific knowledge base [82; 90; 91; 92].

Myth: Sexual orientation is a choice.

Fact: No consensus exists among scientists about the reasons that an individual develops his/her sexual orientation. Some research has shown that the bodies and brains of gay men and women differ subtly in structure and function from their heterosexual counterparts; however, no findings have conclusively shown that sexual orientation is determined by any particular factor or set of factors. Many people confuse sexual orientation with sexual identity. The reader may consider reviewing the definitions of these terms when further considering this myth.

Myth: Gay men and lesbians can be easily identified because they have distinctive characteristics.

Fact: Most gay and lesbian individuals conform to the majority of society in the way they dress and act. Further, a person's appearance is not necessarily an indication of sexual or romantic interests.

Myth: Gay individuals are child molesters.

Fact: This is a very damaging and heterosexist position. According to experts in the field of sexual abuse, the vast majority of those who molest children are heterosexual. The average offender is a White heterosexual man whom the child knows.

Myth: Gay people want to come into our schools and recruit our children to their "lifestyle."

Fact: Efforts to bring issues related to LGBTQIA history and rights into schools are not efforts to "convert," just as education on European history is not an effort to glamorize or "convert" to European identity. The intent has been to teach a more complete history of the world and to prevent children from mistreating LGBTQIA individuals, who are often the subjects of harassment and physical attacks. There is no evidence that people could be "recruited" to a gay sexual orientation, even if someone wanted to do this.

AGE

Elderly patients should be routinely screened for health and mental health conditions using tools specifically developed for this population, in spite of some practitioners' discomfort with asking questions about sensitive topics. These population-appropriate assessments may be included in other health screening tools [93].

Wellness and purpose have become important emphases when working with older adults [94]. In the past, aging was associated with disability, loss, decline, and a separation from occupational productivity. Although patient growth and positive change and development are values that practitioners embrace, the unconscious acceptance of societal myths and stereotypes of aging may prevent practitioners from promoting these values in elderly individuals [95].

Common Myths of Aging

Society holds several myths about the elderly. Many of these myths may be easily disputed based on data from the U.S. Census and other studies.

Myth: Most older adults live alone and are isolated.

Fact: In 2018, 70% of men and 46% of women 65 years and older were married. An estimated 28% lived alone [96]. According to a survey conducted in 2009, 9 out of 10 individuals 65 years of age and older stated they talked to family and friends on a daily basis [97]. In 2016, an estimated 20% of the U.S. population lived in a household comprised of two adult generations or a grandparent or at least one other generation, compared with 12% in 1980 [97; 98]. This multigenerational household trend particularly affects those 65 years and older, with 21% of these individuals living in multigenerational households in 2016. This group was second only to individuals 25 to 29 years of age (33%) [98]. Several factors have contributed to this trend, including growing racial and ethnic diversity and adults getting married later [97; 98].

Myth: Most older adults engage in very minimal productive activity.

Fact: In 2016, 18.6% of persons 65 years and older were employed or actively looking for work, and this population represents approximately 8% of the total labor force in the United States [99]. The elderly are more engaged in self-employed activities than younger persons. In 2016, 16.4% of those 65 years of age and older were self-employed, compared with an average of 5.5% of those 16 years to 64 years of age [100].

Myth: Life satisfaction is low among the elderly.

Fact: Data from the Berkeley Older Generation Study indicate that many elders are quite satisfied with their life [101]. More than one-third (36%) of persons older than 59 years of age and 15% of those older than 79 years of age stated they were currently experiencing the best time in their lives.

A 2009 survey found that 60% of individuals 65 years of age and older stated they were very happy. A 2012 survey found that 65% of individuals 65 years of age and older indicated that the past year of their life has been normal or better than normal, and more than 80% of respondents agreed with the statement, "I have a strong sense of purpose and passion about my life and my future" [102]. Most of the factors that predict happiness for the young, such as good health and financial stability, also apply to the elderly. Older adults tend to report higher levels of well-being in part due to the quality of their social relationships [103].

PERSONS WITH MENTAL OR PHYSICAL DISABILITY

Americans with disabilities represent a large and heterogeneous segment of the population. The prevalence of disability varies by age group and definition. Based on the U.S. Census Bureau's 2013 American Community Survey (ACS), which describes disability in terms of functional limitations, 12.6% of the civilian U.S. noninstitutionalized population has a disability, defined as difficulty in hearing or vision, cognitive function, ambulation, self-care, or independent living [104]. The U.S. Department of Education, which uses categorical disability labels, estimates that 13% of children and youth 3 to 21 years of age have a disability (defined as specific learning disabilities, speech or language impairments, intellectual disability, emotional disturbance, hearing impairments, orthopedic impairments, other health impairments, visual impairments, multiple disabilities, deaf-blindness, autism, traumatic brain injury, or developmental delay) [104].

People with disabilities experience many health disparities. Some documented disparities include poorer self-rated health; higher rates of obesity, smoking, and inactivity; fewer cancer screenings (particularly mammography and Pap tests); fewer breast-conserving surgeries when breast cancer is diagnosed; and higher rates of death from breast or lung cancer [104].

Disability cultural competence requires appreciation of social model precepts, which recognize patients' rights to seek care that meets their expectations and values. The social model of disability has been characterized as centering disability as a social creation rather than an attribute of the patient [105]. As such, disability requires a social/political response in order to improve environmental factors affecting access and acceptance [105]. This involves adoption of person-first language, acknowledgement of social and environmental factors impacting persons abilities, and confronting disability-associated stigma.

VETERANS

The effects of military service and deployment to military combat on the individual and the family system are wide-reaching. According to the U.S. Department of Defense, there were 3.5 million current military personnel in 2020 and 18.3 million veterans in 2017 [132; 133]. The Army has the largest number of active duty members, followed by the Navy, the Air Force, and the Marine Corps [132]. Military service presents its own set of risk and protective factors for a variety of mental health issues, including post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression and suicide, substance abuse, and interpersonal violence. In particular, transitioning from combat back to home life can be particularly trying for veterans and their families.

As the number of military conflicts and deployments has increased since 2001, the need to identify and provide better treatment to veterans and their families has become a greater priority. The first step in providing optimal care is the identification of veterans and veteran families during initial assessments, with an acknowledgement that veterans may be any sex/gender and are present in all adult age groups [133].

Unfortunately, veterans and military families often do not voluntarily report their military service in healthcare appointments. In 2015, the American Medical Association updated its recommendations for social history taking to include military history and veteran status [134]. In addition, the American Academy of Nursing has designed the Have You Ever Served? Initiative to encourage health and mental health professionals to ask their patients about military service and related areas of concern [135]. This program provides pocket cards, posters, and resource links for professionals working with veterans and their families. Recommended questions for intake include [135]:

• Have you or has someone close to you ever served in the military?

• When did you serve?

• Which branch?

• What did you do while you were in the military?

• Were you assigned to a hostile or combative area?

• Did you experience enemy fire, see combat, or witness casualties?

• Were you wounded, injured, or hospitalized?

• Did you participate in any experimental projects or tests?

• Were you exposed to noise, chemicals, gases, demolition of munitions, pesticides, or other hazardous substances?

DIETARY CONSIDERATIONS

Cultural or personal beliefs can also impact the dietary needs of patients, which, in turn, can affect their health and adherence to prescribed treatments. For example, health issues related to fasting may arise among Buddhists, Hindus, Muslims, and some Christian patients, as well as persons of other faiths. This may particularly become an issue during extended fasts, such as the Muslim observance of Ramadan, which continues for one month [148]. Fasting is done during Ramadan as a spiritual exercise and is mandatory for all healthy adults. Those exempt from Ramadan fasting include children (prior to the onset of puberty); developmentally disabled individuals; the elderly; those who are acutely or chronically ill, for whom fasting would be detrimental to health; travelers who have journeyed more than approximately 50 miles; and pregnant, menstruating, or breastfeeding women

[148]. Practitioners should advise all patients for whom fasting would prevent healing or adequate care (e.g., inability to take medication) to postpone or abstain from the ritual, if possible [148].

Another dietary consideration for some patients is whether medications contain animal-sourced ingredients. Vegetarians, vegans, Jewish people, Muslims, and others may need to know which products are from animal sources. Common examples of meds that contain ingredients from animals include:

• Desiccated thyroid from pig thyroid glands

• Heparin from pig intestines

• Pancreatic enzymes from pig pancreases

• Certain vaccines grown in eggs

• Conjugated estrogens from pregnant mares' urine

In addition, the gelatin used to make capsules and even some tablets and vaccines is often hydrolyzed collagen from animal tissues. Over-the-counter medications and supplements that may have animal-source ingredients include glucosamine (from shellfish), vitamin D3 (from lanolin, or sheep's wool), calcium (from oyster shells or bone meal), and omega-3 fatty acids (from fish oils).

PROMOTING CULTURALLY SENSITIVE COMMUNICATION

Communication, the process of sending a message from one party to another, consists of both verbal and nonverbal components. Verbal and nonverbal communications are embedded within the culture of the parties disseminating the information and within the culture of the parties receiving the information. Communication is complex and multilayered because it involves unstated, implicit rules about a variety of factors, including physical distance between parties, tone of voice, acceptable topics of discussion, physical contact, and amount of eye contact [106]. Each of these variables is influenced by the perception of the level of formality/informality of the situation. Frequently, misunderstandings occur because the decoding and interpretation of these nonverbal cues are not accurate.

The verbal component of communication is just as complicated. Certainly, similarity in language shared by both parties enhances communication, but assuming that both parties in a conversation speak the same language, how the information is interpreted is still influenced by a host of factors. Linguists have posited that approximately 14,000 different meanings and interpretations can be extracted from the 500 most common English words [107]. Consequently, practitioners must be aware of the different communication styles held by diverse ethnic minority patients, as the clinical communication process is the primary vehicle by which problems and solutions are identified and conveyed [108].

Styles of communication can be classified from high- to low-context [109]. High-context cultures are those cultures that disseminate information relying on shared experience, implicit messages, nonverbal cues, and the relationship between the two parties [107; 110]. Members of these cultural groups tend to listen with their eyes and focus on how something was said or conveyed [106; 109]. On the other hand, low-context cultures rely on verbal communication or what is explicitly stated in the conversation [107]. Consequently, low-context communicators listen with their ears and focus on what is being said [106; 109; 110]. Western culture, including the United States, can be classified as a low-context culture. On the other hand, groups from collectivistic cultures, such as Asian/Pacific Islanders, Hispanics, Native Americans, and African Americans, are from high-context cultures [109].

Communicators from high-context cultures generally display the following characteristics [106; 107; 110; 111]:

• Use of indirect modes of communication

• Use of vague descriptions

• Less talk and less eye contact

• Interpersonal sensitivity

• Use of feelings to facilitate behavior

• Assumed recollection of shared experiences

• Reliance on nonverbal cues such as gestures, tone of voice, posture, voice level, rhythm of speaking, emotions, and pace and timing of speech

- Assimilation of the "whole" picture, including visual and auditory cues

- Emotional speech

- Use of silence

- Use of more formal language, emphasizing hierarchy between parties

On the other hand, low-context communicators can typically be described as [106; 107; 110]:

- Employing direct patterns of communication

- Using explicit descriptions and terms

- Assuming meanings are described explicitly

- Utilizing and relying minimally on nonverbal cues

- Speaking more and often raising their voices (more animated, dramatic)

- Often being impatient to get to the point of the discussion

- Using more informal language; less emphasis on hierarchy, more equality between parties (more friendly)

- Being more comfortable with fluidness and change

- Uncomfortable using long pauses and storytelling as a means of communicating

Understanding the distinctions between individuals who come from high- and low-context cultures can promote cultural sensitivity. However, it is vital that practitioners take heed of several words of caution. First, it is important not to assume that two individuals sharing the same culture (e.g., low-context culture) will automatically have a shared script for communicating. Second, it is important to not immediately classify an individual into a low- or high-context culture because of their ethnicity. A Chinese American man may not necessarily be a high-context communicator because he is Asian. A host of factors, such as level of acculturation, upbringing and socialization, education, and family immigration history, will all play a role in how one learns to communicate. Third, a major criticism of the discussion of low-/high-context cultures is that

they reinforce dualism and ultimately oversimplify the complexities and nuances of communication [112].

Learning to communicate effectively also requires an understanding of how different conversational traits influence the communication process, or how information is conveyed and interpreted. Again, the goal of this section is not to simply dichotomize individuals' conversational styles into categories, but rather to understand the factors that play a role in how someone makes a decision on how to communicate [106].

As long as there are two parties involved in a conversation, nonverbal communication is inevitable, and it becomes salient particularly when it is processed from one culture to another. Nonverbal communication is any behavior (including gestures, posture, eye contact, facial expressions, and body positions) that transcends verbal or written forms of communication [113]. Nonverbal communication can enhance or reinforce what is said verbally, and conversely, it can completely contradict the message communicated verbally. It can also end up replacing what was verbally communicated if both parties do not share a native language [114].

In Western culture, communication is more direct and eye contact is highly valued. When eye contact is not maintained, many Westerners assume that the party is hiding pertinent information. However, in some cultures, reducing eye contact is a sign of respect [108]. Conversely, patients may interpret direct and indirect gazes differently. For example, in one study, Japanese individuals tended to rate faces with a direct gaze as angry and less pleasant compared with Finnish participants [115].

The amount of social space or distance between two communicating parties is culturally charged as well. Depending upon the social context, Westerners tend to maintain a distance of about three feet, or an arm's length, in conversations [107]. In a public setting, where both parties are engaged in a neutral, nonpersonal topic, Westerners will feel encroached upon and uncomfortable if an individual maintains

a closer conversational distance. However, in other cultures, such as Latino and Middle Eastern, a closer distance would be the norm [107]. Chung recommends that in a clinical setting the practitioner allow patients to set the tone and social distance [116]. The practitioner can sit first and permit the patient to select where they want to sit.

Cross-cultural communication is by no means simple, and there is no set of rules to merely abide by. Instead, promoting culturally sensitive communication is an art that requires practitioners to self-reflect, be self-aware, and be willing to learn. Therefore, as practitioners become skilled in noticing nonverbal behaviors and how they relate to their own behaviors and emotions, they will be more able to understand their own level of discomfort and comprehend behavior from a cultural perspective [106].

CULTURALLY SENSITIVE ASSESSMENT GUIDELINES

Practitioners may be categorized as either disease-centric or patient-centric [117]. Disease-centered practitioners are concerned with sign/symptom observation and, ultimately, diagnosis. On the other hand, patient-centered practitioners focus more on the patient's experience of the illness, subjective descriptions, and personal beliefs [117]. Patient-centered practice involves culturally sensitive assessment. It allows practitioners to move assessment and practice away from a pathology-oriented model and instead acknowledge the complex transactions of the individual's movement within, among, and between various systems [118].

Practitioners who engage in culturally sensitive assessment nonjudgementally obtain information related to the patient's cultural beliefs, overall perspective, and specific health beliefs [119]. They also allow the patient to control the timing [120].

The goal is to avoid the tendency to misinterpret health concerns of ethnic minority patients. Panos and Panos have developed a qualitative culturally sensitive assessment process that focuses on several domains [119]. Each domain includes several questions a practitioner may address in order to ensure that he or she is providing culturally responsive care.

Alternatively, Kleinman suggests that the practitioner ask the patient what he or she thinks is the nature of the problem [121]. He highlights the following types of questions that may be posed to the patient [121]:

- Why has the illness/problem affected you?
- Why has the illness had its onset now?
- What course do you think the illness will follow?
- How does the illness affect you?
- What do you think is the best or appropriate treatment? What treatment do you want?
- What do you fear most about the illness and its treatment?

Similar to Kleinman's culturally sensitive assessment questions, Galanti has proposed the 4 Cs of Culture [122]:

- What do you call the problem?
- What do you think caused it?
- How do you cope with the problem?
- What questions or concerns do you have about the problem or treatment?

Pachter proposed a dynamic model that involves several tiers and transactions, similar to Panos and Panos' model [123]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional must be willing to acknowledge that they do not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups they come in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [123]. Pachter advocates the notion that there is tremendous diversity within groups. Often, there are many intersecting variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the patient and the professional [123]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. The professional might recommend a combination of alternative and Western treatments.

Beckerman and Corbett further recommend that recently immigrated families be assessed for [124]:

- Coping and adaptation strengths
- Issues of loss and adaptation
- The structure of the family in terms of boundaries and hierarchies after immigration
- Specific emotional needs
- Acculturative stress and conflict for each family member

Practitioners should seek to understand the sociopolitical context of the origin country [125]. A migration narrative is also recommended, whereby an individual provides a story of their migration history. Asking about how long the family has been in the United States, who immigrated first, who was left behind, and what support networks are lacking gives the practitioner an overview of the individual's present situation [126]. The theme of loss is very important to explore. Types of losses may include family and friends left behind, social status, social identity, financial resources, and familiarity [126]. For refugees and newly immigrated individuals and families, assessment of basic needs (e.g., food, housing, transportation) is necessary [125].

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. Practitioners should work to recognize that there are a host of factors that contribute to patients' multiple identities (e.g., race, gender, socioeconomic status, religion) [127].

CREATING A WELCOMING AND SAFE ENVIRONMENT

Improving access to care can be facilitated, in part, by providing a welcoming environment. The basis of establishing a safe and welcoming environment for all patients is security, which begins with inclusive practice and good clinician-patient rapport. Shared respect is critical to a patient's feeling of psychological well-being. Security can also be fostered by a positive and safe physical setting. For patients who are acutely ill, both the illness experience and treatment process can produce trauma. This is particularly true if involuntary detainment or hospitalization is necessary, but exposure to other individuals' narratives of experienced trauma or observing atypical behaviors from individuals presenting as violent, disorganized, or harmful to themselves can also be traumatic. As such, care environments should be controlled in a way to minimize traumatic stress responses. Providers should keep this in mind when structuring the environment (e.g., lighting, arrangement of space), creating processes (e.g., layout of appointments or care systems, forms), and providing staff guidance (e.g., nonverbal communication, intonation, communication patterns). During each encounter, the patient's perception of safety is impacted by caretakers and ancillary staff.

Experts recommend the adoption and posting of a nondiscrimination policy that signals to both healthcare providers and patients that all persons will be treated with dignity and respect [128]. Also, checklists and records should include options for the patient defining their race/ethnicity, preferred language, gender expression, and pronouns; this can help to better capture information about patients and be a sign of acceptance to that person. If appropriate, providers should admit their lack of experience with patient subgroups and seek guidance from patients regarding their expectations of the visit.

Front office staff should avoid discriminatory language and behaviors. For example, staff should avoid using gender-based pronouns, both on the phone and in person. Instead of asking, "How may I help you, sir?" the staff person could simply ask, "How may I help you?" Offices that utilize electronic health records should have a system to track and record the gender, name, and pronoun of all patients. This can be accomplished by standardizing the notes field to document a preferred name and pronoun for all patients [129]. Some persons who identify as non-binary (i.e., neither or both genders) may prefer that plural pronouns (e.g., they) be used.

Questions should be framed in ways that do not make assumptions about a patient's culture, gender identity, sexual orientation, or behavior. Language should be inclusive, allowing the patient to decide when and what to disclose. Assurance of confidentiality should be stressed to the patient to allow for a more open discussion, and confidentiality should be ensured if a patient is being referred to a different healthcare provider. Asking open-ended questions can be helpful during a history and physical.

The FACT acronym may be helpful for healthcare providers. Providers should:

- Focus on those health issues for which the individual seeks care
- Avoid intrusive behavior
- Consider people as individuals
- Treat individuals according to their gender

Training office staff to increase their knowledge and sensitivity toward persons will also help facilitate a positive experience for patients.

CONCLUSION

Culture serves as a lens through which patients and practitioners filter their experiences and perceptions. Patients will bring their unique life stories and concerns to the practitioner, and their cultural values and belief systems will inevitably shape how the problem is defined and their beliefs about what is effective in solving the problem. However, the cultural backgrounds and values of patients are not necessarily scripts that define behavior, and when practitioners view culture as a strength and not a pathology, practitioners will be able to more effectively join with patients to mobilize change.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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