CULTURAL COMPETENCE FOR HEALTHCARE PROVIDERS: UNDOCUMENTED IMMIGRANT LATINO/A PATIENTS

by

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Dedication

A tribute to Seth Sonny La, the kindest human being I have ever met. Thank you for showing me that everyone deserves a chance regardless of intelligence, appearance, gender, age, or sexuality. You taught me how special loyalty, respect, and visibility are to others. I promise to help shine lights on those that society casts shadows on. I only wish you could be here to illuminate the world with me.

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Firstly, I could not have written without the generous help of the UHCL advisors and mentors who helped me compose this project. The first half of 2022 was challenging for me, and I appreciate all their advice and leniency. I never received such compassion and guidance during my medical training.

Without my sisters, who helped me and gave me insight and suggestions, I would have probably lost my passion and hope a long time ago. The inspiration and motivation I draw from you all are what made me proud to write this project. My parents both immigrants have supported me and ensured I finished what I set out to do.

For my friends. The only reason I came up with this project was because of your life stories. Your worries and fears for the health of your parents and family members who have been sick and alone in the hospital did not fall on deaf ears. I worry about them too. I want to show others how to care for them and make them feel safe during challenging times.

ABSTRACT

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Sheila Parvanah Zare
University of Houston-Clear Lake, 2022

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The United States' relationship with immigrants is complicated. Economically the country utilizes the labor and services many immigrants provide at an unethically reduced cost. Historically labor has been imported from other countries, with a heavy focus on Latin America in recent years, and foreign policy has been implemented to augment this approach. However, politically immigrants are often used as scapegoats for unemployment and crime, including human trafficking. Unfortunately, many Latino/a undocumented immigrants are forced into situations where their standard of living directly impacts their health. In the United States, healthcare is inaccessible to undocumented immigrants regardless of the cause of their ailments. Most of the United States has failed to address access to healthcare for undocumented immigrants, and the health care system has become so privatized that compassionate care and acute health

services, which have access delegated by local governments, are the only option for undocumented immigrants.

The purpose of this project is not to prove that policy can be implemented to improve access to healthcare, nor is it to prove that the undocumented population is a burden to the system. Instead, it will focus on educating individual providers about how to better assess undocumented patients by understanding their culture and concerns. This project will present a handout informing providers of cultural considerations that help build rapport with Latino/a immigrant patients. It also includes an overview of the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition Text Revision (DSM-V-TR, APA, 2022) components that focus on cultural assessment.

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CHAPTER I:

INTRODUCTION

The diversity in the city of Houston is driven by many economic and sociopolitical factors. Data from the U.S. Census Bureau (2020) reveals that 67.5% of the foreign-born population residing in Houston were born in Latin America, 20.5% born in Asia, 7.0% born in Africa, and 4% born in Europe. Capps & Ruiz Soto (2018) found that in 2016 almost 30% of immigrants in Houston were undocumented. According to the U.S. Census Bureau (2020) report, the city's largest minority population was Latino/a, accounting for 44.1% of the population.

Undocumented immigrant health is a concern in the United States, not only in medicine but also in many political spaces. One cause for concern is that undocumented immigrants are not eligible for private or federal health insurance programs; therefore, the main form of care available to undocumented immigrants is emergency care, one of the most expensive forms of health care (Thomsen, 2015). Almost half of the undocumented immigrants in Houston are eligible for government programs; however, many do not apply to programs for which they are qualified because they do not have access to the proper resources (Capps & Ruiz Soto, 2018). Lack of access and funding contributes to this population's major health concerns, which are chronic health issues that go untreated and result in emergency room visits for preventable complications of these diseases (Thomsen, 2015).

Understanding the situation and background of this group of individuals and how their health is affected by environmental stressors can improve provider care. Regardless of documentation status, immigrants experience immigration stress, which includes loneliness and homesickness caused by the distance between themselves and their family, culture, and home (Joseph, 2011). There is a deficit in our understanding of how the

social stressors that undocumented immigrants experience regarding their family, financial prospects, living situations, and traumatic experiences impact their health. To understand unique stressors affecting patients, providers should be proactive in learning about the sociopolitical histories involving marginalized patients. In doing so, providers will better understand their patients' specific needs and experiences. Because the population of undocumented immigrants is predominantly Latino/a; for the details concerning cultural components will focus on Latino/a culture (U.S. Census Bureau, 2019).

The health of undocumented immigrants has been assessed in a handful of settings in the United States, and focus has centered on physical health and chronic disease management. Patients who are undocumented may not have the financial resources to visit a primary care physician regularly (Chávez et al., 2021). In addition, institutionalized discrimination fails to give this population access to preventative care, which could cheaply and efficiently reduce this care burden (Thomsen, 2015). This form of discrimination is based on larger-level conditions that affect specific populations and limit access to resources based on race/ethnicity and other statuses such as immigrant status. One form of discrimination that affects undocumented immigrants' access to healthcare is the financial burden (García, 2018). Most undocumented immigrants are ineligible to enroll in federal or state assistance programs, which include Medicaid, Medicare, and the Children's Health Insurance Program. Harris County has a financial assistance plan to provide services at county-run hospitals and clinics, and the primary enrollment requirements for the financial assistance plan are proof of income, identification, and residency in the county. Of the three, the latter is the most difficult. Many undocumented patients are not able to prove they reside in Harris County. This is an important program for undocumented immigrants because they are ineligible for

enrollment in private or federal insurance programs. The best way to understand how our healthcare system discriminates against undocumented patients is to recognize that the healthcare system was not made to provide care to a migrant population. Instead of including this population, the system has sidelined these patients. Instead of directly addressing barriers to patient care or instituting policies to address this problem, patients must work around the system. Undocumented patients report that when interacting with healthcare providers, they are most concerned about lacking insurance, exposure of immigration status, community health clinic dependence, and perceiving receipt of care at hospitals as a last resort (Chávez et al., 2021). The solution for overcoming these barriers is twofold; first and foremost, policy needs to address our growing migrant patient population and work to institute programs that grant resources to undocumented patients. Secondly, and most easily managed, is for providers operating in the system to make patients aware of resources they can access. Providers also need to be mindful that while the policy may or may not change, the approach to understanding patients can and should.

This project will introduce important cultural considerations for assessing mental health among undocumented immigrant patients. To accomplish this, it will highlight this population's unique stressors and effects on patient care. There will also be a discussion of cultural considerations for difficult conversations and religious concerns of patients. Finally, it will cover the DSM-V-TR with the cultural formulation interview and the major cultural concepts of distress that affect the Latino/a population.

Undocumented Immigrants and Healthcare

Much work has been done to investigate the social aspects of health, and this rapidly growing branch of public health research has targeted social factors that affect individual and community health. For example, research shows that documented

immigrants' health outcomes are better than those of their children and subsequent generations (Ahmed et al., 2009). However, Ahmed et al. (2009) found that undocumented immigrants are less likely to visit a physician than other groups of Latinos/as. This lack of patient presence in clinics is a potential reason for the lack of literature on undocumented immigrant health demographics. In addition, some of the information concerning undocumented immigrant health comes from detainment facility health services. In these situations, health can be affected by the conditions individuals are in, and, because detainment can have adverse health effects on undocumented immigrants, this may significantly skew data. Two such studies, one from a facility in Arizona and the other from the Netherlands, indicate that acute issues, such as injuries, trauma, and dehydration, were the most prominent medical issues among undocumented detainees (Dorn et al., 2011; Wong et al., 2015). While this information is valuable for understanding the traumatic experiences of undocumented immigrants, it lacks detail regarding established health issues in the country and the issues that undocumented immigrants face outside of detainment facilities.

While Houston is not a sanctuary city, it has adopted many "sanctuary-like" policies. A sanctuary city has community policing policies and other forms of immigrant protection (Iten et al., 2014). Assessment of immigrant health in a sanctuary city is more accessible since public institutions, such as hospitals, are permitted to recognize one's immigration status without stigmatization. Research by Iten et al. (2014) in San Francisco's Bay Area and Chicago reveal that, under sanctuary policies, diabetes management for undocumented immigrants is statistically indistinguishable from documented immigrants and US-born Mexican Americans. This evidence from sanctuary cities provides insight into how effective changes in policy can improve care and patient outcomes. Resources available to undocumented immigrants in Houston include state

policed federal programs. Such as the Supplemental Nutrition Assistance Program, Medicaid, and the Children's Health Insurance Program. However, Harris County is highly selective in its administration of Medicaid to undocumented immigrants, largely due to state restrictions in provisions (Sommers, 2013). County resident can also enroll in local programs like the Harris Health Financial Assistance Program. This program grants patients access to county clinics, which include Federally Qualified Health Centers (FQHCs). Although these clinics are federally funded, often there is limited availability for patients, and it can take months to be seen. Many patients receiving care at FQHCs experience exacerbations or worsening of health conditions and receive care for acute or emergent conditions instead of primary preventative care (Martinez et al., 2013).

The sanctuary-like policies Houston has implemented provide enrolled undocumented immigrants with access to select health resources. As a result, access to health care remains limited for undocumented immigrants in Houston, with most of these individuals only receiving care when they develop a chronic illness that requires urgent treatment (Thompson, 2015). Frequently, undocumented immigrants unable to get proper health care provisions in the United States are advised to return to their home country for support, and patients in demanding situations face social issues and pressures, primarily stigma about their undocumented status, not to get the health care services they need (Tenorio, 2014). For example, a young woman with diabetes, hypertension, and end-stage renal disease was sent to the emergency room after experiencing a syncopal episode at work. After receiving acute care, she did not have the resources for the treatment she needed to control her kidney disease. She had to leave against medical advice due to her family's need for social and financial support, which she provided. Other contributors such as institutional mistrust, language barriers, lack of health literacy, lack of financial

resources, and access are also factors that cause immigrants to refrain from seeking traditional healthcare services (Tenorio, 2014).

Barriers to health care not only prevent undocumented immigrants from accessing care but are also a source of stress that can aggravate health conditions (García, 2018). Undocumented immigrants also face many new stressors in the United States that may impact their health (Sommers, 2013). Acculturative stress, deportation stress, work-related stresses, anxiety, depression, marginalization, and acculturation are predominant contributors to health outcomes (Martinez et al., 2013). Understanding how these stressors impact undocumented immigrants will provide insight into the needs of this population.

One particular stressor unique to this population is the stress of anti-immigrant discrimination (Joseph, 2011; Martinez et al, 2013). The internalization of anti-immigration stigmas is well documented and understood to contribute to immigrants' poor mental health. Research by Chandler et al. (2012) involved interviews with undocumented Mexican immigrant women, which revealed that these individuals often felt "unimportant and unworthy" in healthcare settings.

Another unique stressor for undocumented immigrants is acculturative stress, a circumstance that the individual perceives as detrimental but has no resources to overcome. Joseph's work (2011) claims that, among the undocumented population, physically strenuous jobs, being undocumented, and quality of life expectations are prevalent indicators of poor mental health. Acculturative stress can relate to any of the stressors previously highlighted, and these stressors are included in Arbona et al.'s (2010) work, which focuses on intrafamilial and extrafamilial stressors. Intrafamilial stressors include within family problems, while extrafamilial stressors include outside stressors that impact individuals. Arbona and colleagues (2010) found that undocumented

immigrants report higher levels of extrafamilial stress than their documented counterparts. They note that the lack of variation in intrafamilial stress between documented and undocumented immigrants may be because of their loyalty to the cultural value of familism. Familism pertains to the strong bonds individuals have with their families and the emphasis placed on dedication to their families (Marin & Marin, 2011). Marin and Marin (2013) report that familism may cause respondents to underreport issues within the family and that separation from family, lack of English proficiency, and endorsing traditional values all contribute to higher levels of extrafamilial stress. While stress is known to impact the development of chronic disease, individuals experience stress differently. Importance should be placed on understanding life experiences and stressors when treating and educating patients. Recognizing the unique stresses of being undocumented is essential to learning how to best provide care for these individuals and will potentially reduce their experiences of stigmatization within healthcare settings. Understanding the circumstances of this population and their health outcomes provides a valuable resource for delivering a higher quality of care and higher satisfaction for patients.

Immigrant Acculturation and Provider Cultural Competence

The acculturation process is a stressful change that occurs throughout an individual's migration experience (Romero et al., 2013). This is especially true when an individual emigrates from a culture different from the one they immigrate into. Romero et al. (2013) details the difficulties that many Latino/a immigrants experience and highlight the linguistic barrier, different gender expectations, and a diverse religious landscape's effects on patients. All of these components serve as potential concerns to explore with patients. If providers are not aware of these cultural values, they may not be able to help this patient population adequately.

In provider cultural competence training, it is crucial to gain insight into how aspects of life affect our patients and how to approach the essential social norms of our Latino/a immigrant patients (Westermeyer, 1989). Understanding an individual's stress due to acculturation and bicultural tension is a multifactorial process. When evaluating these stressors, the best approach is to consider that an individual's identity may need to adapt to various aspects of life depending on their social context (González & González-Ramos, 2005). Understanding that patients may experience bicultural stress due to this cultural dissonance is essential, as unaddressed stressors can lead to depressive symptoms, diagnosis of adjustment disorder, anxiety, and alcohol use disorder, and participation in risky behaviors among many immigrant groups (González & González-Ramos, 2005; Romero, 2013)

Providers can better convey their compassion to patients by learning about the social barriers they experience. This will equip providers with more cultural humility when communicating the value of our treatment recommendations and the importance of mental health services, and it may empower our patients in learning how to access and utilize health care resources. Some patients maintain a bicultural sense of health care by revisiting their home country and seeking medical treatment or diagnostic studies (Wong, 2015). Most of the time, this is a decision made out of economic necessity. Providers must understand that this resourceful solution is a choice patients must make and utilize these alternative resources when necessary.

Providers should understand that Latino/a migrants experience unique daily stressors, such as fear of deportation, family fragmentation, and economic uncertainty (García, 2018), and many patients will not be able to adhere to common treatments for high stress due to social limitations. Among other limitations, undocumented patients may not have the time and resources required for exercise, therapy, and pharmacologic

interventions. Instead, the literature proposes that providers attempt to incorporate alternative culturally inclusive behaviors that improve wellness for our patients (Westermeyer, 1989). Undocumented Latino/a patients may choose to rely on cultural practices and kinship or social networks to provide health services, and they may meet health needs by relying on alternative methods, such as local healers and traditional practices (Juckett, 2005). This includes religious and spiritual engagement and alternative medicine in Latino/a culture referred to as Curanderismo which includes practices like limpia (spiritual cleansing), herbal remedies, and plática (intimate discussion; Tafur, 2009). These practices are essential to many patients and can be therapeutic for some. However, these traditional practices do not always resolve health problems for patients, and the role of western medical treatments and therapies must be emphasized.

Latino/a Immigrant Religiosity and Provider Conversations

When considering the mental health of Latino/a immigrants, it is essential to address an individual's religiosity and spirituality. Religion can be a protective or risk factor when considering mental health (McCord et al., 2004). McCord (2004) explains that many immigrants have strong social networks related to their place of worship and these support groups can offer help. This is important to consider when your patient needs social support or community resources when navigating difficult decisions. Revens et al. (2021) emphasizes that, among Latino/a immigrants, religiosity and social support are predictors of increased resilience and lower symptoms of depression.

Given the importance of social support and religiosity in health outcomes for Latino/a immigrants, health care providers should incorporate these factors when providing care for this population, and while social support and religiosity may be topics more easily discussed in primary care settings, it may be particularly impactful to include these factors in acute care settings. Ellis et al. (2013) found that spiritual struggle affects

almost 30% of inpatient admissions, and 94% of patients who received religious support visits found these services helpful. Using chaplain consults and provider acknowledgment of faith can help patients overcome severe duress and anxiety when they are hospitalized. Some patients are willing to discuss their faith with providers openly and even request providers and ancillary staff to engage in prayer. Ellis et al. (2013) observed that eight percent of patients desire spiritual interaction with their physician. However, very few receive such interactions, and patients have also expressed a desire to discuss values concerning severe illness, treatment decisions, and personal strength with their providers (Rahee & Petel, 2022). Physicians need to be aware of the religious services their institutions offer. It should also be the physician's role to discuss treatment outcomes with their patient without being influenced by sociopolitical concerns. Official documentation by chaplains is standard in the inpatient setting, and physicians must review assessments and concerns documented by chaplains so they can be discussed with patients. Unfortunately, these discussions are not customary practice for most physicians (Ellis et al., 2013; Rahee & Petel, 2022).

Most patients do not have long-term relationships with their providers in inpatient settings, so it can be challenging to discuss social support and religiosity. However, McCord et al. (2004) found that most patients want these discussions because they report it will help the physician understand their preferred care and decision-making values. The Office of Research of the Northeastern Ohio Universities College of Medicine Department of Family Medicine details fourteen questions that can help the provider understand how a patient's faith influences their health decision-making process. This can be a valuable tool for physicians who struggle with having these conversations with patients (McCord, 2004). The questionnaire begins with open-ended questions that allow the patient to dictate the contents of the interview by considering past patient-provider

interactions concerning religion and spirituality. Next, there is a transition to close-ended questions that relate to illness and belief system. Finally, it ends with two lists of close-ended questions. The first list details situations in which patients would want their beliefs considered during their treatment, and the second list inquires about the value the patient has in such conversations. This approach to discussions about spirituality and beliefs is a helpful framework for clinicians who are not sure how to discuss religion with patients. In addition, it is beneficial for patients such as Latino/a immigrants whose faith, health, and decision-making are all very strongly correlated to patient outcomes (Koenig et al., 1998).

Physicians should be able to discuss confidentiality, HIPAA, and patients' rights indiscriminately so that patients can make informed decisions and understand our health care systems and practices. When having these sensitive conversations, ensuring your patient feels empowered and has control of the situation is crucial. The culturally competent provider can achieve this by considering the values of simpatia (kindness), personalismo (relationship), and respeto (respect) when providing culturally competent care to Latino/a migrants. These values allow for better personal engagement with patients and improve patient-provider communication, outcomes, and satisfaction (Juckett, 2013).

DSM V-TR and Cultural Awareness

It was not until 1994 that the DSM-IV published a guide for culturally sensitive psychiatric interviewing (Lewis-Fernández, 2015). The DSM-IV included the Outline for Cultural Formulation (OCF), used as an assessment during psychiatric evaluation to guide clinical diagnosis and strengthen patient engagement in treatment planning. The OCF was intended to allow providers to assess how individuals' relationship with their culture affects their diagnostic indicators and treatment options. The interview contains

four major themes: cultural identity, a cultural explanation of the illness, cultural factors related to psychosocial environment and functioning, and cultural elements of the physician-patient relationship (Lewis-Fernández et al., 2015). The final component was to assess the patient's cultural context as a component of the patient's social background and view the clinical pathology with such a context in mind. According to Lewis-Fernández et al. (2015, p. 2), it can help "identify causal explanations and meanings of illness by the patient and by his or her family and community and extends a biopsychosocial formulation into the realm of cultural assessment."

Aggarwal et al. (2015) explains that the first theme, cultural identity, attempts to utilize an "interpersonal grid" to put into perspective the facets of culture that can change over time and depend on a patient's social environment. The culture identity theme is highly personalized and impacts a patient's illness expression and help-seeking behaviors. The second theme, cultural explanations of illness, allows the provider to investigate a patient's concerns about symptoms, cultural norms, illness views and models, cultural concepts of distress, experiences with care, and treatment planning (Aggarwal et al., 2015). This is relevant when considering the Latino/a migrant population, who may express more somatic symptoms or have a standard cultural script of illness and have specific expectations for treatment and relief (Romero et al., 2013). A script common among the Latino/a migrant population is distress due to sinful behavior or unfaithful actions. These individuals can present with frequent prayer or increased church attendance, which is different from a religious obsession or fixation (Romero et al., 2013). The OCF also encourages investigation into how culture impacts one's psychosocial environment and levels of functioning. In doing this, the physician can better determine the relationship between the illness and the individual's cultural background. Assessing the patient's internal experience through the lens of their social

and cultural spheres is recommended (Lewis- Fernández et al., 2015). For instance, if an individual's culture perceives their illness as a burden or a gift, this may affect how the patient is able or allowed to function according to their cultural norms. During this part of the interview, culture should be screened as a potential stressor, primarily if it directly affects the patient's health (Aggarwal et al., 2015). Clinicians should also understand how these stressors relate to a patient's values and decision-making process. Lastly, the clinician inquiries about the patient's expectations of the clinician and the anticipated relationship (Lewis- Fernández et al., 2015). Direct questioning of the patient should include their history of experiences with clinicians and their preferences for relationship style. During this time, it is helpful to consider the physician's perception of their dynamic with the patient; one should also consider if cultural transference and countertransference affect their relationship with the patient (Aggarwal et al., 2015).

Upon publication of the DSM-V in 2013, the Cultural Formulation Interview (CFI) was published as an instrument to provide a formal evaluation for the OCF. The main changes expanded the framework of the OCF from the DSM-IV. The CFI aims to guide physicians in identifying key stressors the patient may experience and how they affect the patient's social background. In addition, this amendment was made to specifically include the areas of religion, sexuality, race, and discrimination (Lewis-Fernández et al., 2015). Shortly after publication of the DSM-V, the Handbook on the Cultural Formulation Interview was published and explicitly details how and when clinicians should use the CFI. The DSM-V-TR was subsequently published in 2022 and is imbued with dialogue that considers variation in pathophysiology subject to cultural influence. It also includes information on cultural norms that affect the pathopsychological profile regarding symptom severity and functionality, and it explicitly

informs of potential inappropriate diagnoses misattributed among specific ethno-racial or marginalized groups due to cultural influences (APA, 2022).

Lewis- Fernández et al. (2015) established the CFI as a three-part assessment. The first component is the core, a set of sixteen questions that guides the physician to assess how the patient identifies with their culture directly. The second component targets a third-party informant with a personal relationship with the patient. The informant interview is collateral information and should not be used to validate or discredit the patient's self-assessment findings (Aggarwal et al., 2015). Instead, it should serve as a separate entity to provide insight into how those closest to the patient perceive their experience. The final component is a set of twelve supplementary modules that expand on topics relevant to the patient's initial core assessment.

The core of the CFI can be broken down into four domains: cultural definition of the problem, cultural perceptions of cause, context and support, cultural factors affecting self-coping and past help-seeking, and cultural factors affecting current help-seeking (Lewis- Fernández et al., 2015). Each domain consists of three to four questions. The interview structure develops from a personal investigation of cultural considerations and stressors to a macroscopic lens to view how culture may affect therapy and treatment options for the patient.

The informant component of the CFI allows clinicians to understand the interpersonal relationships a patient has and their impact on an individual's psychosocial environment. There are also some instances where an informant's testimony will more reliably depict the social and cultural background of the patient. This becomes difficult when the patient and their associated informants have different cultural values. Lewis-Fernández et al. (2015) explains that this can lead to differing explanatory models for psychiatric disorders and conflicting approaches to interpersonal care. In such situations,

providers should discuss perspectives nonjudgmentally with a basis on the psychopathologic context of the condition driving the conversation.

The final component of the CFI is the supplementary modules. Unlike the previous two elements, the provider chooses supplemental modules that depend on the core interview results. Eight of the twelve modules expand on a component from the core allowing for further investigation of the relevant core concepts. In addition, these modules should expand on contextualizing the clinical situation and the individual's cultural schema (Lewis- Fernández et al., 2015). Three modules target concerns about special populations. The three special populations are older adults, children and adolescents, and immigrants and refugees. These modules allow for specific assessment of identity and stressors that may be particularly relevant for the respective groups. The final supplementary module is for caregivers and is meant to be considered after the administration of the CFI informant interview. This module assesses cultural components of the caregiving experience, including their response to the patient's diagnosis and treatment system and caregiver burden and response (Lewis- Fernández et al., 2015).

DSM-V-TR and Cultural Concepts of Distress

Including cultural concepts of distress in the DSM allows for diagnostic assessment to consider expressions of distress that are subject to cultural variance. The American Psychiatric Association (APA, 2022) states that cultural concepts of distress are classified into three categories: cultural concepts of distress, cultural explanations of symptoms, illness or distress, and cultural syndromes. Cultural concepts of distress can refer to considering a shared experience of personal or social concerns, and this can relate to a specific symptom or the illness schema. The second category cultural explanations is the cultural perception of a cause for someone's distress and can relate to the etiology of specific symptoms, stressors, or illnesses. If a provider is considering a cultural concept

of distress, it is necessary to note that the clinical significance may be ambiguous regarding a direct diagnostic correlation. Providers must also consider the range of symptoms and functional severity the patient exhibits and how these change over time. Cultural concepts of distress are relevant for providers as they allow for a comprehensive assessment to prevent misdiagnosis and improve our ability to identify an individual's concerns and psychopathology. This improves rapport with patients, allows active engagement, and improves care.

The DSM-V-TR is imbued with dialogue that considers variation in pathophysiology subject to cultural influence (APA, 2022). It also includes information on cultural norms that affect the pathopsychological profile regarding symptom severity and functionality, and it explicitly informs of potential inappropriate diagnoses misattributed among specific ethno-racial or marginalized groups due to cultural influences (APA, 2022).

CHAPTER II:

METHODS

In order to produce a beneficial handout for providers, the decision was made to create a three-panel informational pamphlet that could be printed or accessed electronically via PDF document. The information included in the pamphlet must be concise and impactful to be implemented in practice. The front cover will inform the reader of the pamphlet's contents; the appearance will be plain and professional to allow the reader to focus on the content. The colors were chosen to represent the Harris Health System's theme colors. The pamphlet's contents will serve an educational purpose and provide recommendations for clinical practice. Adobe InDesign will be the software application used to create the pamphlet. A three-panel pamphlet layout was chosen because it will deliver a brief, reproducible, and accessible final product. The design layout was chosen based on a reference to multiple handouts viewed in person. See Appendix A below to reference the panel map.

Panel A is the title panel and displays the topics detailed within the pamphlet. Panel B is the panel seen when panel A is lifted. This panel has two parts at the top; it gives a demographic overview of Latino/a immigrants in the Houston area. The bottom part of Panel B introduces a guide to developing rapport with patients. Panel C is the back of the pamphlet seen when it is flipped over. This panel is sectioned into two parts as well. At the top of the panel is a knowledge check section that asks the reader two questions. The first has a straightforward answer from the text and explanation. The second question is open-ended and intended to provoke discussion.

The bottom of the panel will include references to more in-depth resources that will address some of the key cultural topics. The inside panels D-F contain in-depth details about the significant cultural concepts discussed in the literature review. The

topics included will be acculturation stress and social stressors, religiosity and difficult conversations, DSM-V-TR cultural formulation interview learning concepts, and cultural concepts of distress. Most of the content will focus on the DSM components and explain the essential concepts from the relevant DSM chapters. This will include a breakdown of the core of the CFI. It will also provide highlights from the informant and supplement components. The section referring to the concept of distress will detail Latino/a specific concepts such as nervios, ataques de nervios, and sustos. See Appendix B for a copy of the pamphlet. By presenting the information in this format, providers can better assess the importance and depth of this topic. The major highlights are key points for us to address with patients when pertinent. Supporting Latino/a undocumented patients is a skill that can be delivered with experience and developed through practice and expanding one's knowledge base. This pamphlet intends to initiate an understanding of Latino/a experiences and how to approach these topics if they are a concern for patients.

CHAPTER III:

DISCUSSION

Experiences in medical education training are relatively uniform regarding basic sciences, diagnosis, and treatment of disease. However, there is variation in how much exposure providers have to cultural competence training and implementation (Lim et al., 2015). Some programs have elective courses for their trainees to participate in, some have mandatory classes, and others have no courses at all (Thomsen, 2015). This is a problem because most academic schools will train their providers in hospitals and clinics that serve minority populations. When providers cannot empathize appropriately with their patients, this will only weaken their relationship with patients. It is integral that providers learn what their patients experience on a daily basis, as well as their life experiences, and how those experiences affect their decision-making and ability to establish rapport. Patients are less likely to leave against medical advice when they trust their providers to assist them in making complicated medical decisions. When providers offer patients services they may not know are available, the relationship is reinforced.

The pamphlet will introduce some cultural competency concepts that providers do not consider when interacting with patients. The aim is that providers will consider the restraints of the system (i.e. financial, social, and policy barriers) on the patient when providing care to immigrant patients, especially if undocumented, as well as help providers to think about their cultural humility. The pamphlet serves as an introduction to some key tenants of extracting clinically relevant information from patients as well as building rapport and understanding. However, as with any other high-risk patient group, empathy is most genuine when individually understanding your patient. Many of the concepts from the pamphlet will allow providers to investigate areas of their patients' lives that are important to their patients and provide insight into parts of patients'

experiences that are meaningful to them. This, in turn, allows providers to connect and advise their patients in a more informed manner.

Another lapse in training is the lack of emphasis on the DSM-V-TR. The pamphlet includes a breakdown of DSM-V-TR-related concepts. This is important because most providers do not have exposure to either of these parts of the DSM, which is relevant for their patient population. Understanding cultural concepts of distress is especially useful when patients are troubled or put in difficult decision-making situations. For example, sustos, ataque de nervios, and nervios are the relevant concepts of distress for the Latino/a population regardless of documentation status. In addition, when speaking to undocumented immigrants, providers should inquire about the stress of migration, which is unique to undocumented Latinos/as. As such, clinicians must be able to at least discuss the distress these patients may be experiencing, and these discussions would hopefully help clinicians to recognize symptoms of migration stress. The brief descriptions in the pamphlet not only introduce these concepts but also require that providers probe further to fully understand the details of these culturally distinct expressions of distress. Providers are thoroughly advised about the components and implementation of the CFI in the pamphlet. By doing this, providers can use the CFI as a framework on how to approach a patient's cultural beliefs and relate them to their illness perception.

The discussions that occur between patients and their healthcare teams impact their decision-making. The best way to help patients make these complex decisions is to have informed conversations where patients feel comfortable and resepected. By having conversations with cultural humility, providers will show patients that they are committed to the four tenants of medical ethics: patient autonomy, beneficence, non-maleficence, and justice.

CHAPTER IV:

CONCLUSION

This project aims to provide insight into how to provide culturally competent care to our undocumented Latino/a patients. This purpose is achieved by delivering detailed cultural information and educating providers about some of the population's identities and experiences. A discussion of the DSM-V-TR CFI is included to better evaluate patients and establish rapport. While intended to be used as a tool for psychiatric assessment profiles, it can also provide insight and be a great reference tool for patient assessment. The CFI also serves as a framework for cultural considerations in general. Unfortunately, the CFI is not a component of general medical education (Lim et al., 2015). This is a weakness, especially in metropolitan areas that are home to a diverse patient cohort, including undocumented Latinos/as.

Most medical education programs address social determinants of health; however, there is little training for medical students and residents regarding specific cultural competence training (Lim et al., 2015). Therefore, one of the purposes of this pamphlet is to introduce some concepts that can be clinically helpful for providers to utilize when working with undocumented Latinos/as. Unfortunately, there are many incidences where Latino/a patients are brought to the emergency department and have poor provider interactions, making them distrustful or fearful of the healthcare system. Due to these poor interactions and rapport, patients may choose to leave against medical advice in the face of potentially fatal conditions. The purpose of this project is to show providers a simple way to connect with their patients and decrease distrust and fear by building rapport through conversations with patients that are culturally responsible while maintaining humility.

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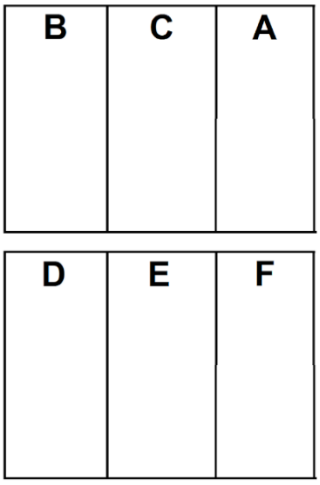
APPENDIX A:

PAMPHLET LAYOUT



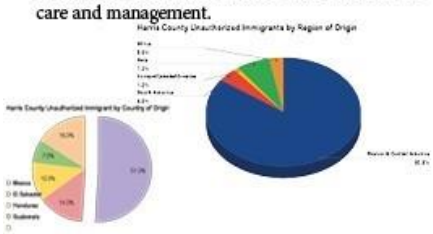
APPENDIX B:

COPY OF PAMPHLET

Figure B1: Pamphlet for print (FRONT)

Harris County Deomgraphics

- Harris county is home to a large population of migrant Latinos/as.
- Providing care to those who are not documented can be difficult due to loss to follow-up, socioeconomic factors, or socio-political climate.
- As you provide care to these patients you should try to asses these barriers your patient may be struggling with and provide services necessary in each situation.
- When interviewing the patient providers should inquire about the individual's culture and beliefs to understand how this impacts their concerns for care and management.



Introduction and Rapport

- The changing landscape of Houston's political climate affects many undocumented patients decision to participate in preventive care.
- Inquire if the patient has recieved medical care in the past year. Have they gone to a different country where they recieved care or work-up? What were their experiences like?
- To address this issue it is reccomend to have a clear candid discussion about their documentation status and if they are eligible for county support and services.
- The last consideration is to inquire about the patient's experience with migration.

Knowledge Check

What is the differential diagnosis for sustos?

A. MDD and GAD
B. GAD and BPD
C. MDD and PTSD
D. GAD and Panic Disorder
E. PTSD, Panic Disorder, MDD
F. GAD, MDD, Panic Disorder

A 62 yo spanish speaking female from Honduras presents to the ED for a fractured pelvis due to a fall from standing. How would you approach a non-english speaking patient who is insisting on leaving AMA? Consider how you might express personalismo, simpatia and respeto during your conversation.

For more resources regarding cultural competence and latino/a patients:

- Houston Kinder Institute
- Pew Trust
- Mental Health Care for New Hispanic Immigrants
  By: Marcia Finlayson, Manny J Gonzalez, vGladys M Gonzalez-Ramos
- DSM V-TR Guide to the CFI

Cultural Competence: Address Mental Health Concerns for Migrant Latinos/as

Demographics
Undocumented Immigrant Stressors
Religion and Difficult Conversations
DSM V-TR Cultural Concepts of Distress
DSM V-TR Cultural Formulation Interview (CFI)

Figure B2: Pamphlet for print (BACK)

Undocumented Immigrant Stressors

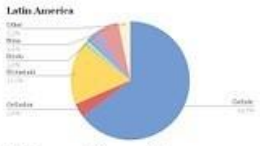
Cultural shock, work-related stresses, anxiety, depression, marginalization, and acculturation are predominant contributors to health outcomes.

Considerations:

- Ask your patients how many hours a week they work, what are their work conditions like (do they work outside, do they get a break, what kind of shifts do they work, overtime?)
- Have they been trafficed? (labor, sex, bondage) Who is their employer, are they being undercompensated, where and who do they live with?
- How are they adjusting to life in the U.S. ?
- Do they belong to any social groups or communites, what do they enjoy doing after work, are their family members in the United States, have they been able to communicate or go visit them?

Religion and Difficult Conversations

Many Lationo/a undocumented migrants are christian with almost 82% being Catholic or Protestant. Thus it is important to approach informed decision making with an awareness of our patient's moral standing.



- Have a conversation with your patient concerning:
- Rescuscitation status, family planning, chaplain mediation.
- Many patient's report that having discussions with providers about their faith relives feelings of anxiety and improves rapport with their physicians.
- There are also three important cultural values that are rooted in Christianity.
  1. Simpatia (kindness)
  2. Personalismo (relationship)
  3. Respeto (respect)

Culturally competent care should be considerate of these values when interacting with patients.

Examples:

- Making sure to communicate honorifics and use proper introductions and greetings.
- Ensuring modesty when the patient may be exposed, or offering a sex matched provider perform the exam/procedure.
- To establish a personal relationship with patients it is helpful to engage in anectdotal conversation.
- One line of inquiry most patients respond well to is where and how they grew up. This can also provide insight into medical history and the patients interactions with physicians in their home country.

DSM V-TR Cultural Concepts of Distress

The DSM V-TR describes distress schemas patients experience linked to stress or trauma.

Latino/a cultural concepts of distress:

1. Sustos- Attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness, as well as difficulties functioning in key social roles.

   Symptoms include: appetite or sleep chages; troubled sleep or dreams; feelings of sadness, low self-worth, or dirtiness; and somatic symptoms.

   Differential diagnosis: MDD, GAD, PTSD
2. Nervios- individuals are stressful to life experiences and difficult circumstances.

   Symptoms: emotional distress, somatic disturbance, and inability to function.
3. Ataques de nervios- usually triggered by an intense stressor or traumatic experience.

   Symptoms: dissociation, have suicidal thoughts, attacks of crying, or feel anxious or angry.

   Differential diagnosis: panic disorder, dissociative disorder, and functional neurologic disorder.

DSM V-TR CFI

The Core Interview

15 questions that investigate the patient's culture and illness.

Introduce the topic of cultural idenity and provides examples of identities that may be important for the patient, such as language, ethnicity, religion, and sexual orientation.

What is the most important component of their identity, and how does it impact your current illness experience, predicament, or clinical situation?

Have you ever seeked help within and outside of the biomedical system such as religion-based support, support groups, or traditional healers?

Are there any perceived differences with the clinician that could adversely affect care?

Informant component

This may be someone who has a strong or long relationship with the patient. It can be secheduled as a family meeting or conducted over the phone.

Similar to the core investigate cultural beliefs of key informants, to allow a deeper understanding of the patient's illness and the interpersonal dimensions of care. Differences in cultural context allow for development of shared understandings of illness and treatment goals.

Supplemental Modules

One supplement module is specific for immigrants and refugees. It focuses on topics such as premigration difficulties, migration related challenges, relationship with country of origin, resettlement, relationship with health, and future expectations. If your patient expresses one of these investigate further by asking for the impact of these potential concerns.