Dialog Across Cultures

Therapy for Diverse Families

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KEYWORDS

• Cultural humility • Family-based care • Acculturation • Mental health
• Cultural factors • Diverse families

KEY POINTS

- Culture defines the way families and clinicians understand mental health conditions.
- Families and clinicians of minority populations are negatively influenced by systemic racism, racial discrimination, social determinants of health, and potentially acculturative family distancing.
- Through family-based care, providers can mitigate impact of structural inequities and acculturative stress on youth and families of minority population.
- Cultural humility, curiosity, and respect are essential for successful family-based care.
- Family therapy-based strategies can help navigate situations where providers and families are misaligned in their goals, expectations, and values.

INTRODUCTION

The COVID-19 pandemic has highlighted health-care inequities and social injustices experienced by families of racial and cultural minorities.[1] Before the pandemic, up to 36% of children and youth in the United States experienced poor mental health.[2]

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Race and culture-based disparities in diagnosis and treatment are well established.[1] Because the medical community makes efforts to address these inequities, medical culture needs to align and speak a shared language of respect and understanding. More importantly, making behavioral health care accessible and welcoming for all youth and families who need it, helps mitigate negative impact of mental health on youth development.

Focusing exclusively on distress omits aspects of wellness. Seventy-five percent of children and youth in the United States report positive indicators of mental health.[2] Because culture often mediates protective factors, culturally attuned child and adolescent psychiatrist (CAP) better reinforce the strengths and supports that promote mental well-being. This article describes the best practices for culturally informed and inclusive child and adolescent psychiatric care with a family focus. Although written from the perspectives of CAPs, the clinical dynamics are common to all clinical interactions and the recommendations are universally relevant.

Orienting to the Dialog Across Cultures

Culture defines identities, roles, values, and norms. Most mental health disorders affecting children are not spontaneous or genetic but rather develop through a complex interplay of various cultures and relationships surrounding a child. For example, a child may present as reflection of the turmoil in family life, of being part of a school system that does not meet their social, emotional, and learning needs, of daily experiences of invalidation, and of different cultural expectations in their social environment. Furthermore, family and systems issues mediate all psychiatric disorders, even those with clear neurobiological causes, such as psychosis and attention-deficit hyperactivity disorder.[3,4] Culture also influences relational dynamics and guides decision-making. In every clinical interaction with a child, there are multiple cultures present, including the family's culture(s), the clinician's culture(s), and the culture(s) of clinical practice. Therefore, to provide a comprehensive assessment and treat children, CAPs must engage with families and understand with them the impact of the various cultures present.

Guidance for Successful Family Engagement

Providers: dialog with self

Psychiatric practice demands engaging in life-long learning of understanding our blind spots, explicit and implicit biases, positions of power, presumptions of responsibility, and ways that we perpetuate dominant cultural norms. Self-reflection, language and behavior change, and taking responsibility for correcting missteps fosters transparency, collaboration, and acknowledgment of historical and ongoing oppression. These are cornerstones of trauma-informed practice.[5] Learning from others, through reading published works and participating in discussions, workshops, and trainings, helps deepen understanding and reinforce learning.[6,7]

For white CAPs in the United States, whose racial identity is the default and norm against which others are judged, some of the efforts to understand internalized racial superiority may be new and unsettling. For minority CAPs, this study may uncover ways that certain privileges and racial oppression have been internalized, as well as harms accumulated. The health of all of us depends on the healing of each of us. "There are no safety nets, no shortcuts, and no easier routes."[6] When the clinician's nuanced understanding of their whole self is present, it invites families to share their whole selves.[8]

Dialogs and the Practice of Cultural Humility

There is inherent power and privilege that comes with being a CAP, which requires recognition and responsibility. Clinicians must meet families where they are and aim with them where they dream to be, while avoiding imposing our expectations.[9] The hidden curriculum in medical education and practice includes valuing competency over humility, a tradition of patriarchal treatment.[10] Thus, one needs to take the step of unlearning these assumptions to foster partnership and to better support children and families. Although the medical model assumes assessment and diagnosis are work done by the clinician, cultural humility and person-centered care includes prioritizing collaboration and allowing families to define their concerns, set their own goals, and guide treatment plans. Cultural humility is a stance that is person oriented, includes reflection and self-evaluation, and is also structurally aware, recognizing and working to correct power differentials as they show up in clinical practice.[11] There is a higher likelihood of missteps in treatment when cultural humility is not practiced. Missteps that occur too early or are too great may threaten the therapeutic alliance and the goal of engaging the family. Reflecting and learning from examples of early aborted treatments are important growth opportunities. Although starting the interview primarily with the child may be effective in some settings to help the child feel comfortable, in other settings, the parents may feel left out, distrustful of the process or may benefit from initial interventions aimed at partnering and aligning.

An example of alliance missteps includes the work of 2 nonindigenous CAPs working with a young indigenous man, who was brought to care by his mother at the request of the school for behavioral concerns and a question of exposure to violence. In the middle of the first interview, the mother abruptly ended the session, noting "my son isn't comfortable with these questions." The questions had been directed mainly at the child and involved asking him to share about himself. He began sharing his passion for a horror film, which had been part of the school's concerns. Initial reflections as to the reasons for this discomfort included considering the impact of the mother's trauma history and history with Child Protective Services (CPS), which may have affected her view of the providers in this clinic. Further reflection on the CAPs' lack of understanding of this mother's values, her potential ambivalence with regards to seeking treatment, and her experience of being criticized by the clinicians, CPS, and school, highlights a critical need to hear families and understand their life experiences. Introductions that include clinicians' intentions may be an olive branch for many families amid numerous negative interactions with systems.

Dialog that Engages a Family Holistically

Families seek the support of CAPs in many contexts. Contextual understanding is critical to family engagement to effectively work with children and adolescents, no matter the cultural background. The presenting problem is created, maintained, and sustained within the family system context and, thus the treatment is best addressed in the family system context. To create a welcoming space to discuss difficult circumstances that families have experienced, it may be beneficial to start from the family's experience. **Box 1** identifies ways to engage families holistically.

It is worthwhile to spend time early in treatment getting to know each family member outside of the context of the presenting problem. Starting from a place of strengths and hopes for a better future, we acknowledge that each person is more than their problems. *Share something about you that is unrelated to our meeting today.* When identifying the positives in a family, the CAP recognizes their competence and highlights what they are good at or care about.[12]

Box 1
Skills for engaging with families and working through challenges

- Awareness of your bias and blind spots
- Welcome and seek understanding of the culture of the family
- Learn from mistakes, ruptures, and impasses
- Explore how the family's cultures and intersectionalities affect the problem and their goals for resolution with curiosity and humility
- Validate injustices and exclusions
- Collaborate with the family to reframe the problem to a shared achievable goal
- Understand the context of engagement
- Assess family vital signs

The CAP may want to ask the family about their journey to the present moment. This maybe an immigration journey, response to the experience of discrimination, response to the experience of feeling different, and their response to the challenges of stigma and exclusion. Such dialog begins the relationship of respect with the appreciation of resilience and struggle experienced by the family.

As the conversation moves toward the primary reason to seek care, CAPs must take the responsibility for setting the frame for a successful treatment. Often CAPs assume that families know how the treatment works and what the likely outcome will be of the engagement. For example, a family mandated to treatment by CPS or the legal system may enter treatment with different hopes, fears, and expectations than one self-referred or referred by a trusted provider. Similar to many parents from marginalized groups, immigrant parents can feel disenfranchised, shamed, blamed, or fearful when the school, the state, or another authoritative agency mandates an evaluation for their child. Thus, their expectation of the treatment is likely to be different. Aligning with the parents demonstrates respect for their expertise as parents and can create the foundation to move toward an understanding. It is an understanding of the different perspectives (of child, parents, CAP, and other systems) on mental illness, the meaning all parties involved make of the illness and its impact.

Careful validation and reframing are the required skill when families seek treatment where the youth is the identified patient, as a reflection of the family turmoil. Similarly, providers must focus on the larger picture of seeing families within their systems when multiple systemic issues are involved. For example, when a family may present as quite distressed and disorganized due to social and structural determinants of health and intergenerational trauma, in addition to cultural factors that may be at odds with the medical and mental health systems.

A CAP's ability to assess the family contextually depends on cultural and intersectional factors relevant to a family, and the ability to take a culturally humble stance. Furthermore, exploring the ideas and values of each family from a nonassuming and curious stance helps us avoid assumptions or judgments about a family based on our idea of "sameness" or "difference," especially, when working with diverse families. Additional factors that can add complexity to a family include preimmigration trauma, acculturative family distancing (AFD), trauma related to being different from the immediate community, generational racism, and the relationships between the cultures in the room. Exploring the intersectionality of the family's identity, particularly around

aspects of marginalization, prejudice, and oppression (racial/ethnic, gender/sexuality, religious minority, and so forth) can be an important part of the healing process for families. For example, *how does a family whose culture and values prioritize autonomy or privacy interact with a CAP whose medical culture may prioritize risk reduction or safety?*

Family vital signs, conceptualized as the emotional climate, family flexibility, connectedness, parental relationship quality and authority style may all be impacted by cultural and structural factors.[13] *How did this family arrive at treatment with us? Who is most willing in the family to be in treatment? Who is least willing? What are their hopes of treatment? What are their prior experiences with other 'helpers' or 'systems'?*

Families from oppressed groups or those from communities with historical trauma such as genocide or slavery may present with a great distrust of the medical and mental health system. Engagement in such justified fear of harm contexts requires recognition that trust must be earned. It may be helpful to explicitly invite the family to teach the clinician what will be necessary to build trust. "*Sometimes the medical system or other systems mistreat people. I wonder if that is true for your family and what I can do to make this experience go better.*" To build trust, starting the family conversation with the father figure may make sense for families of strongly patriarchal cultures, whereas starting with elders, if present, may be more appropriate for other families. "*What do you like to be called?*" conveys respect for a patient's autonomy and preferred language. "*Who should we hear from first?*" may also convey a CAP's value of hearing all voices but giving the family preference about how to begin. Additionally, making explicit statements conveying respect to a family for simply showing up can be validating. Acknowledging the range of possible emotions present including shame and fear may help to normalize a family's experience.

One goal of family interventions may be to engage the family in conversations about themselves.[12] When working with immigrant and refugee families, these conversations may be challenged by both generational and cultural gaps specifically because of acculturative stress. Acculturative stress is stress that is experienced by immigrant families when acclimating to the mainstream culture.[14] A family may present with youth engaging in self-harm due to breakdowns in communication and cultural value differences, such as, individuation, separation, gender roles, dating and relationships, career goals, educational goals, the meaning of success, the definition of happiness, and so forth. This breakdown in communication and values between immigrant parents and children is referred to as AFD. AFD is a risk factor for adolescent mental health issues.[15] Often, by the time AFD challenges come to a CAP's attention, "parent-child relationships have become negatively charged, disrespect is predominant, and the family is filled with hopelessness, mutual misunderstanding and hurt. To make matters worse, these problems have often been developing and progressing for some time when the family seeks help, leaving family members fixed in their opinions and with little expectations of change."[14] Families of minority cultures, races, or ethnicities who have lived in their country for generations also contend with acculturation stresses and conflicts, although they may have become acclimated to the degree that is explicitly asking about these stresses is necessary to surface them.[16]

CONDUCTING A CHALLENGING DIALOG

When preparing for the meeting with the family, it is useful to consider few structural components. These include seating arrangements—*who sits close to who*, *which way are they facing*, *where the clinician sits*, and so forth. It is important to be mindful of who is in the room and who is not. *Why is a family member missing? What is the impact*

of their absence? What is their impact at home? Additionally, the CAP must prepare a plan about how to make sure that everyone has a chance to speak. What are the rules around active listening and speaking that need to be explicitly defined? What are the rules around language of respect versus punitive language?

The "Speaker–Listener Technique" is a powerful tool to make conversations clear and safe.[17] See **Table 1** for rules to consider. The task for the clinician is to facilitate discussion while avoiding problem-solving or seeking solutions. The speaker is encouraged to use the "I" statements such as "*I feel*…," "*I saw that*…." After active listening, paraphrasing is helpful: "*What I hear you saying is . . .*," "*Sounds like . . .*," "*If I understand you right . . .*."

Because difficult conversations will be part of any appointment, it is helpful to consider *how different family members support each other and how they maintain a courageous space. How can one ask for a break if one is not feeling safe in the appointment? What should be done to re-engage after such a break? What is the plan if physical safety becomes an issue? Moreover, finally, what should be expected after the appointment? What should happen in-between sessions?*[18]

THE PROCESS OF WORKING WITH FAMILIES

Families often come to treatment unsure of how to deal with their child. For example, when parents are frustrated with their adolescent for attempting suicide and needing hospitalization, one can reframe by saying: "*It seems that worries about your child, and having to miss work is very overwhelming, is that right? Moreover, yet, here you are in the emergency room for your child's wellbeing. I sense a strong bond between you and your child even if it is difficult to experience it at times.*" Turning the attention to moments when family members offer love and support can bridge distance that has emerged and reinforce a positive feedback loop that diminishes the distress associated with the illness or the problem. Highlighting the strengths of the family reinforces the hope that propels healing.[12,19] Identifying the cultural factors and ethnic social capital that are protective and health promoting may validate the connections that are prioritized for family members as well.[19]

Once perspectives are shared, the CAP and family work together to synthesize the problem using each person's perspective in a validating fashion. This process also helps address stigma that may be held by the family, cultural factors affecting acceptance of the challenges, and parents' values. Synthesizing the problem also helps the family prioritize goals and assess which goals are achievable and which needs to be modified. To expand the cultural impact further, Sharma and Sargent (2021) describe that families from different cultures can have different reactions to the reality of this difference (ie, child's challenges). The person experiencing the difference can be seen as "other" and not a full member of the family collective. This can be a source of shame and embarrassment for the family, or seen as a sign of poor parenting. It can feel to the family as a challenge to their sense of community and to belonging. Part of setting the agenda for therapy will always be to understand the family's sense of the difference and their willingness to live with it. Family therapy may promote accommodation to difference with the expectation that with the increased knowledge and comfort with the difference the family becomes less distressed. Knowing the family's way of understanding the difference and honoring their language when describing the situation are a part of the keys for successful treatment.[14]

Aligning around description of the problem and its acceptance is a challenging process. It cannot be done without integrity, curiosity, and respect on the part of the provider.[14] Ultimately, the CAP's goal is to help families negotiate and accept differences

Table 1
Speaker–listener technique

General Rules	Speaker has the floor	Wait for your turn to speak	Respect everyone
Rules for the speaker	Use "I" and speak only for self	Focus on expressing thoughts and feelings	Be brief
Rules for the listener	Confirm/paraphrase what was heard	Ask clarifying questions when it is your turn to speak	Focus on the speaker's message

such that there is better prognosis for the youth's mental health. A striking example of this is how a family acceptance has been noted to improve the parent–child relationship and mental health outcomes of lesbian, gay, bisexual, transgender and queer or questioning youth (LGBTQ) youth.[20] Please see the article titled 'Clinical Considerations in working with LGBTQ+ Youth' for more details.

Once the problem has been defined, the goal is to gather information because it relates to the problem and the relationship between the problem and the family members. Often, at this stage, it may help to personify or externalize the problem as a separate entity, which helps with having a difficult conversation without blaming an individual. For example, a parent may identify their 7-year-old's clingy behavior, difficulty with transition, and inability to sleep independently as the problem. This minority child with anxiety can be identified as the problem by the other parent. By externalizing the anxiety driving the behavior, and calling it by another name such as "*monster*," "*fear*," *or* "*worries*," it may be easier to discuss *how the* "*worries*" *cause change in behavior of the child, how the* "*worries*" *may recruit a parent into agreeing with it, and how the* "*worries*" *exclude the other parent from the unit.*

The circular interview is another strategy that is used to gather information about factors that sustain the problem in the family system. These are a series of questions that identify connections among behaviors, beliefs, feelings, meanings, and relationships as they manifest among family members. An example of circular questions is demonstrated with the case here: An African American adolescent woman being raised by her grandmother and presenting with suicidal ideation may have a difficult time identifying a parent figure who she can talk to openly about these thoughts, particularly if there is ambivalence in the family about the grandmother's role, or where caregiving duties may be a source of responsibility and pride/strength, or, the family culture holds a significant amount of mental health stigma or shame.[21]

Circular questions may help them appreciate each other's point of view*: Is your grandmother aware of the kind of thoughts you've had? How would your grandmother react if you were to talk openly? What would she worry about? What does your grandmother think of your struggles? And to the grandmother: 'what must it be like for her to not have her mom around to turn to for these kinds of struggles? Is she right to feel like a burden? What are your hopes for her … if it's not the role of a grandmother to hear about these kinds of thoughts, whose role is it? What are the sources of support in your family and community?*

At the end of every appointment, it is a good practice to reflect on the process—*what was positive about this appointment? What would you do differently? What are the changes you would want to make in your life? What are the things that you are satisfied with that need to be maintained?* Such reflections and feedback provide more information for future sessions and can inspire changes that family may want to try between sessions. A collaborative contract to attempt a change in family pattern

can be a family eating dinner together, using different language to communicate frustration, changing the role of the disciplinarian. Learning how these changes go, whether positive or negative, or the reasons or barriers to trying them brings additional useful information to understand the family and their relationship to the problem (Table 2).

Dialog to Repair Ruptures

Challenging family dynamics, difficulty understanding the family context, and family's ambivalence can often make the CAP feel "stuck." Assessing each family member's stance on the problem in this process is important. Family's denial of the problem or control over the situation is a set-up for failure based on unrealistic expectations of the clinician role in the treatment. Helping to reframe the problem such that the whole family sees the relational context of the problem and are willing to work with us in a collaborative way on improving the problem are crucial steps toward engagement and a successful treatment.[22]

Working Through a Family's Ambivalence

Family's ambivalence toward treatment can be overt and verbal ("*I don't think this will work.*" "*It is the school's problem.*" "*This is how we do things.*"- *with more cultural elements the conversation*) or subconscious ("*I am trying to help my kid to go to school but, I don't think that school is the right fit.*"). Navigating ambivalence requires the clinician to label the ambivalence and allow for it. When the ambivalence is reenacted in the room, support the family members to support the ambivalent member. Remind the family members of the ultimate goal and focus on change needed while also allowing for an option to change the family goal if one chooses to be adherent to the ambivalence. Working through ambivalence requires patience and ability to allow for 2 opposing ideas to coexist while accepting that this dynamic sustains the problem.

Working Through Communication Challenges

Family communication is how verbal and nonverbal information is exchanged among family members.[23] Facilitating conversations becomes the primary target of family engagement and intervention in situations where conflicts are related to communication issues. Fear of consequence or perceived vulnerability could drive difficulty in conversations, especially when the theme signals safety concerns. In such situations, protective instincts may trigger avoidance, overprotectiveness, or noncollaborative problem solving, all of which do not address the root issue. The family's cultural and ethnic background plays a crucial role in navigating difficult conversations. Thus, CAPs need to follow the principle of active listening by paying close attention to both verbal and nonverbal communication. Requesting clarifications frequently assists in avoiding assumptions. The CAP's role of fostering a discrete connection with each family member while maintaining a semblance of understanding and comfort helps to promote conversations in such situations.

Difficult conversations vary according to the family's communication style, cultural background, and problem-solving skills. Every family has its own communication style that varies depending on the setting, the culture, and the purpose of the conversation.[23] Different styles of conversation between parents and youth can exacerbate the generational gap and contribute to AFD. This occurs especially when the youth are more familiar with the Western European approach of directness, which can be experienced as disrespectful in many minority cultures. This view of direct communication is western-centric and culturally problematic. There are many examples of indirect communication, which is also effective, such as the role of humor in many

Table 2
Family therapy process and outcome goals for each task

Task	Joining and Engagement	Defining Problem	Information Gathering	Redefining the Problem	Reflection on the Process and Contracting
Process goal	Welcoming, understanding the culture of the family, establishing a shared sense of the problem	Better understanding the culture of the family, better defined sense of the problem, ensuring a collaborative team	Continuing to learn the family's unique culture and ways of functioning, recognizing movement toward the shared goals	Reframing the problem, appreciating any losses associated with progress, addressing ruptures	Ensuring the family's satisfaction with the treatment, movement toward termination by practicing strategies at home environment
Outcome goal	Engaged family who commits to the future meeting and has a shared sense of the problem	Deepened connection between the cultural elements and the shared sense of the problem	Identified patterns that sustain and maintain the problem and how it impacts the family members	Revised view of the problem and the role each person plays and renewed interpersonal trust	Family establishes renewed form of rules and commitment by which to resolve current and future problems

cultures as a way to help families navigate difficult scenarios. The clinician's role is to identify the hidden messages in conversation styles and intervene to facilitate an uninterrupted flow while refraining from placing judgment due to the bias of their style, upbringing, and culture.

Working Through Structural Challenges

Structural challenges, such as the logistics of having all or relevant family members attend the meeting, the logistics of transportation and management of other commitments, and access to care, can be barriers to working with families. The COVID-19 pandemic has advanced the acceptance and utility for telemedicine significantly. One should be aware of the impact of telemedicine, positive or negative, in their community. Langarizadeh and colleagues (2017) noted that it allows for improved attendance, increased convenience for some people, and improved access to care, particularly in rural communities with access to reliably robust Internet service.[24] Telemedicine creates an opportunity to engage with families in ways that allows for family members to attend sessions even if they are not cohabitating. Although there are many benefits of telemedicine, it has its limitations, from Internet connectivity to registering nonverbal cues and less flexible interaction during the session.

Beside practical considerations that are necessary for all sessions, in-person or remote, such as seating arrangements, who is in what room, how they support each other, a safety plan during the session, how to ask for a break, and what to expect after the sessions, there are some unique aspects to be mindful for practice of telemedicine.[18] To be specific, the clinician must be familiar with the platform to assist the families with troubleshooting if necessary, consider how many devices are needed to have all members visible, have a plan for connectivity issues, and for the lack of privacy. These barriers must be evaluated before deciding whether telemedicine is the appropriate modality for the family.

Working Through Systemic or Cultural Challenges

When at an impasse in clinical care or uncertain of which concerns to follow, reorienting to familial, cultural, and other systemic impacts can be effective. For example, when the clinical recommendations are ineffective, it may be because the clinician is solving a problem that is not shared by all. A CAP's goal is not always culturally relevant to or a priority for the family. Different aspects of diagnosis and treatment may carry more or less stigma for each family member. Consider raising the question of "*how each family member defines the presenting problem*," "*who expects who to change*," or "*how everyone will know that problem has been resolved*." Listen for influences of cultural factors and life experiences. Retelling stories and renegotiating a shared understanding may encourage curiosity that leads to the discovery of a path forward.[12,14]

Involving an important member of the extended family or community may restart stalled progress. Including the perspective of more people can facilitate understanding and connection to the supports that are instrumental for healing and health. Adding more people may entail consulting with others, making culturally relevant adaptations to a treatment, inviting others to a clinical appointment, or asking those present to bring in the perspective of others important in their life. "*If your grandmother were here, what would she say to each of you?*" Additional people to consider include additional family members, youth or parent peers, cultural navigators, traditional healers, and religious leaders. It may be helpful to inquire about the angels, ghosts, visitors, spirits, or vampire bites that may have been influencing the family.[8,12]

SUMMARY

CAPs work at the intersections of families, cultures, and systems, which affect engagement in care, assessment, and treatment planning. Welcoming youth and their families to share about themselves, their culture, community, faith, social histories, ethnic and racial identities, gender, and sexuality works to foster understanding, strengthen therapeutic alignment, clarify diagnosis, reinforce strengths and supports, guide treatment recommendations, and promote healing. Acknowledging intersectional relationships among identities and communities, as well as relationships with other systems the child and family interact with, clarifies the experiences that shape stressors, distress, opportunities, and access to resources. Providing the most inclusive and comprehensive child psychiatric treatment also requires the CAP's understanding of one's own culture, biases, and internalized beliefs to counter harm, promote connection, make repairs, learn, and authentically foster sharing. There are several practical strategies that CAPs can apply to practice cultural humility, to join families, to facilitate difficult conversations and to work through misalignment to help families of all backgrounds to have conversations together, identify their strengths and work toward their goals. A family and cultural frame widens the lens and broaden the scope of what is possible for all individuals involved in otherwise tenuous or seemingly treatment resistant clinical cases.

CLINICS CARE PEARLS

- Cultural humility is the person-centered approach that limits implicit bias and allows child and adolescent psychiatrists to understand the family's values, goals, and perspective.
- Validation, reframing, contextual understanding for the reason of the meeting, and assessing the family vital signs are skills that help engage family holistically.
- When the provider and the family are not aligned, focusing on joining the family, redefining the problem, gathering the appropriate information and then, reflecting on the process can be helpful.

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The above authors have no disclosures.

REFERENCES

1. Protecting youth mental health: US surgeon general advisory. 2021. Available at: https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf. Accessed March 2022.
2. Bitsko RH, Claussen AH, Lichstein J, et al. Mental health surveillance among children — United States, 2013–2019. MMWR Suppl 2022;71(Suppl-2):1–42.
3. Sharma N, Sargent J. Overview of the evidence base for family interventions in child psychiatry. Child Adolesc Psychiatr Clin N Am 2015;24(3):471–85.
4. Onwumere J, Bebbington P, Kuipers E. Family interventions in early psychosis: specificity and effectiveness. Epidemiol Psychiatr Sci 2011;20(2):113–9.
5. Substance Abuse and Mental Health Services Administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884. Rockville (MD): Substance Abuse and Mental Health Services Administration; 2014.

6. Saad LF. Me and white supremacy: combat racism, change the world, and become a good ancestor. Naperville (IL): Sourcebooks; 2020.
7. Kendi IX. How to be an antiracist. New York: One World; 2019.
8. Duran E. Healing the soul wound: counseling with American Indians and other native peoples. 2nd edition. New York: Teacher's College Press; 2019.
9. Ginwright S. Trauma-informed care and the future of healing. [Keynote address] 2019 the Northwest children's Foundation Community Forum, Seattle (WA).
10. Brooks KC. A piece of my mind. A silent curriculum. JAMA 2015;313(19): 1909–10.
11. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved 1998;9(2):117–25.
12. Combrinck-Graham L. On being a family systems thinker: a psychiatrist's personal odyssey. Fam Proc 2014;53(3).
13. Wood BL, Woods SB, Sengupta S, et al. The biobehavioral family model: an evidence-based approach to biopsychosocial research, residency training, and patient care. Front Psych 2021;12. https://doi.org/10.3389/fpsyt.2021.725045.
14. Sharma N, Sargent J. Family therapy with diverse families. In: Ranna P, Al-Mateen CS, Lisotto MJ, et al, editors. Cultural psychiatry in child and adolescent psychiatry. Washington (DC): American Psychiatry Association Publishing; 2021. p. 151–63.
15. Kane JC, Johnson RM, Iwamoto DK, et al. Pathways linking intergenerational cultural dissonance and alcohol use among Asian American youth: the role of family conflict, parental involvement, and peer behavior. J Ethn Subst Abuse 2018;18: 613–33.
16. Jones J, Begay K, Nakagawa Y, et al. Multicultural counseling competence training: adding value with multicultural consultation. J Ed Psych Consultation 2016;26(3):241–65.
17. Markman H, Stanley S, Blumberg SL. Talking safely without fighting. Speaker Listener Tech. In: Fighting for your marriage: positive steps for a loving and lasting relationship. 3rd edition. San Francisco (CA): Jossey-Bass; 1994. p. 106–33.
18. Levy S, Mason S, Russon J, et al. Attachment-based family therapy in the age of telehealth and COVID-19. J Marital Fam Ther 2021;47(2):440–54.
19. Pearrow M, Sander J, Jones J. Comparing communities: the cultural characteristics of ethnic social capital. Educ Urban Soc 2019;51(6):739–55.
20. Ryan C, Russell ST, Huebner D, et al. Family acceptance in adolescence and the health of lgbt young adults. J Child Adolesc Psychiatr Nurs 2010;23(4):205–13.
21. Weaver A, Greeno CG, Fusco R, et al. Not just one, it's both of Us": low-income mothers' perceptions of structural family therapy delivered in a Semi-rural Community Mental Health Center. Community Ment Health J 2019;55:1152–64.
22. Madsen W. Collaborative therapy with multi-stressed families. 2nd edition. New York: The Guilford Press; 2007.
23. Epstein N, Bishop D, Baldwin L. (1982) The McMaster Model of Family Functioning: a view of the normal family. In F. Walsh (ed.) Normal Family Processes (pp. 15–141). New York: Guilford Press. 138–160.
24. Langarizadeh M, Tabatabaei MS, Tavakol K, et al. Telemental health care, an effective alternative to conventional mental care: a systematic review. Acta Inform Med 2017;25(4):240–6.