

American Medical Association

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Delivering
Culturally Effective Health Care
to Adolescents

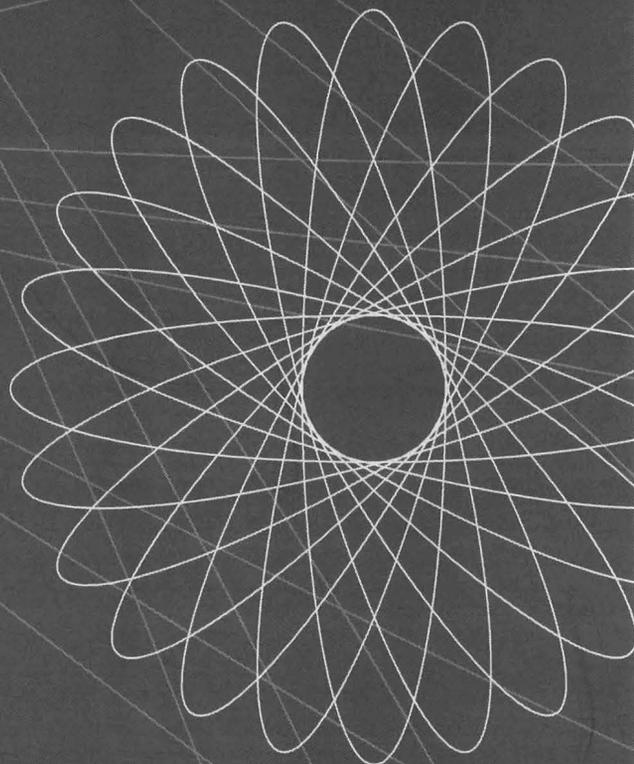


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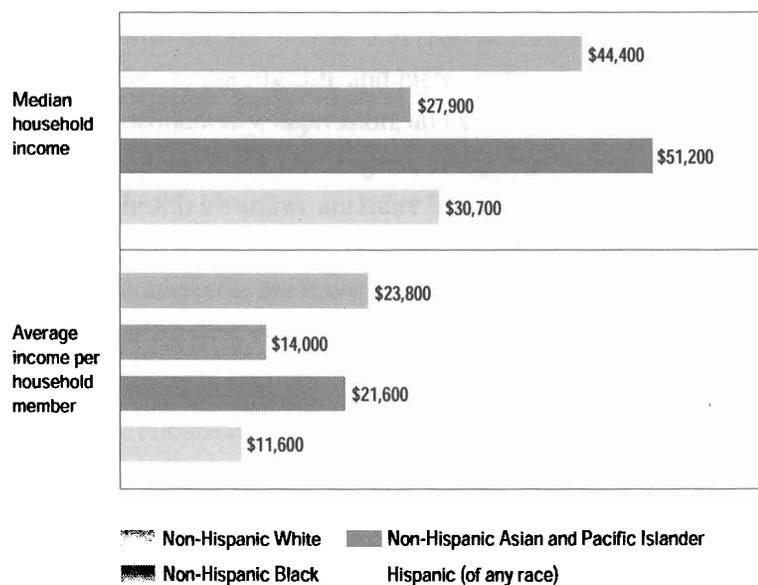
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Income varied for different ethnic and racial groups. For instance, white non-Hispanic, black, and Hispanic households experienced the highest-ever recorded median income in 1999. Asian and Pacific Islander households experienced a similar increase, but it was not significantly different from 1998. The following chart demonstrates these differences (US Census Bureau, 2000).

Median Income for Households and Average Income Per Household Member by Race and Hispanic Origin of Housholder: 1999

(1999 dollars rounded to the nearest \$100)



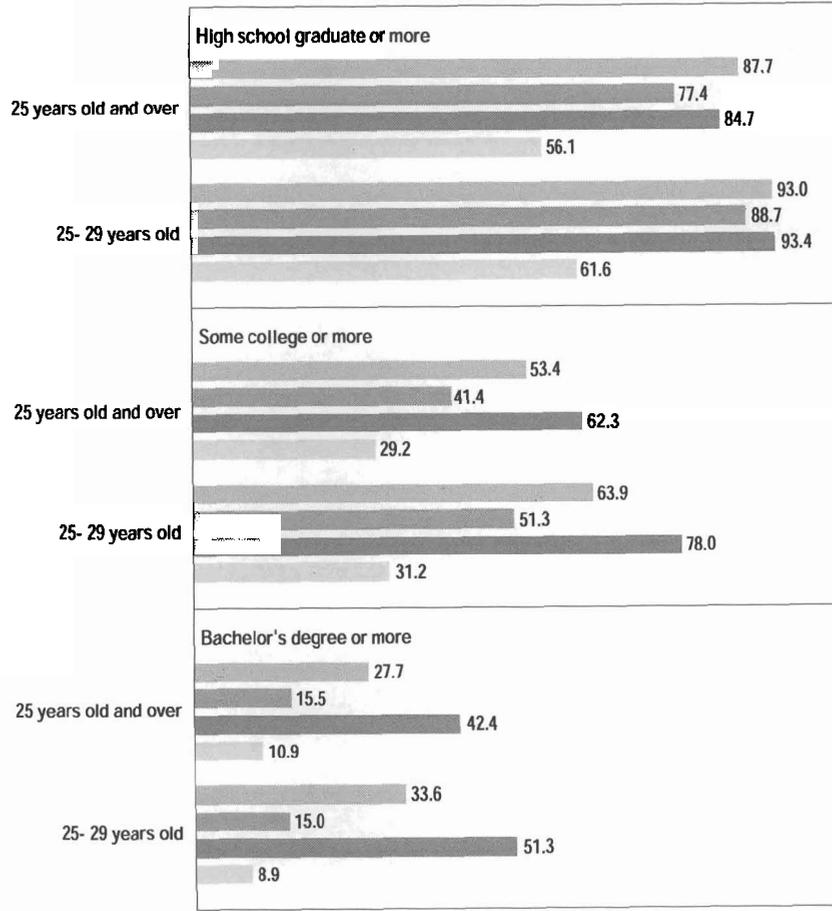
Source: U.S. Census Bureau, Current Population Survey, March 2000.

An adolescent patient's family economic status is important to understand because it is an aspect of his or her culture. Socioeconomic status can have a strong influence on adolescents' perceptions of health, their health behaviors, their use of health care, and their ability to comply with a treatment plan. Socioeconomic factors may also influence adolescents' health by determining the type of social and physical environment in which they grow and develop. Consider the following factors that may vary by socioeconomic status for adolescent patients.

- Access to health care
- Choice of friends
- Available options for employment or education
- Perceived and real opportunities for mobility and vocational success

Differences in Educational Attainment by Race, Hispanic Origin, and Age: March 1999

(in percent)



Non-Hispanic White
 Non-Hispanic Asian and Pacific Islander
 Non-Hispanic Black
 Hispanic

Note: Hispanics may be of any race.
 Source: U.S. Census Bureau, Current Population Survey, March 1999.

Educational attainment may be a sensitive topic for adolescents, especially if they are immigrants from another country or if their parents were not born and educated in the US. Assessing the influence of education could enhance physicians' understanding of this aspect of a young person's culture. Consider the following questions as a way in which to obtain this type of information.

- What are parental/family personal educational values?
- What are parental/family educational values for the adolescent?
- What are the adolescent's own educational values?
- What does the adolescent patient hope to gain from the educational experience?
- How does the adolescent plan to reach his/her educational goals?
- Are any of these plans and goals in conflict with family educational plans and goals for the adolescent?

Population characteristics and access to health care

Learning a few characteristics about different population groups can be informative. The following profiles describe five racial and ethnic groups that are outlined in the 2000 census; these groups also represent patient populations that physicians may encounter in clinical practice. These profiles include general descriptions of adult populations and their families in addition to some information about health care access.

Note: Information about racial and ethnic populations other than the five groups profiled in the recent census is not as readily available for statistical analysis. Interested physicians who treat the many groups of patients who are not described in this chapter can consult the Resource Organizations section for additional information.

Because differences within racial and ethnic groups can outweigh differences between various groups of people, consider the following descriptions as an overview of general information. Data on ethnic and racial groups vary across populations and reflect the need for continued research.

American Indian and Alaska Native

According to the US 2000 census, people who identify themselves as American Indians and Alaska Natives increased to 2.5 million and may represent as many as 4.1 million people if the new mixed race categories are included. The increase is due primarily to individuals who formerly identified themselves as another race (*May, 2001*). American Indian and Alaska Native populations are concentrated in California, Oklahoma, Arizona, Washington State, Alaska, North Carolina, and Texas (*University of California, Los Angeles, 2000*). Urban Indians make up 55% to 70% of the American Indian

and Alaska Native population and may reside in states other than those with the highest concentration.

Similar to many other ethnic groups, American Indians and Alaska Natives are considered seriously disadvantaged. Almost half of all non-elderly American Indians and Alaska Natives are poor or near poor and have family incomes below 200% of the federal poverty levels. The proportion of this population group who worked on a full-time, full-year basis remained unchanged between 1994 and 1997 (*University of California, Los Angeles, 2000*).

The US government has a trust responsibility to provide health care for American Indians and Alaska Natives. American Indians receive health care through Indian health programs that include the Indian Health Service, tribal health programs, and urban health programs. However, an estimated 30% of Native Americans lack health insurance and access to the Indian Health Service and tribal facilities (*Hall, 2001*). Other sources of health care include Medicaid, Medicare, private insurance, and traditional Indian medicine. American Indian life expectancy is 5 years less than that of the general population, and death rates are significantly higher for alcoholism, tuberculosis, diabetes, accidents, suicide, pneumonia and influenza, and homicide (*Association of American Indian Physicians, 2001*).

Asian and Pacific Islander

In 1999 slightly more than half of the Asian and Pacific Islanders lived in the western United States, with about 20% in the South, 18% in the Northeast, and 10% in the Midwest. Most Asian and Pacific Islanders live in metropolitan areas, and about one third are younger than 18 years (*Humes & McKinnon, 2000*). Asian and Pacific Islanders live primarily in California, New York, Hawaii, New Jersey, and Washington State (*Population Profile, 2001*).

Young adult Asian and Pacific Islanders are more likely than non-Hispanic whites never to have married, and married couples maintain the majority of the Asian and Pacific Islander families. Their families are larger than non-Hispanic white families, with almost one quarter having five or more members. Asian and Pacific Islanders who are 25 years old and older are more likely to have earned a college degree than non-Hispanic whites; however, they are also more likely than non-Hispanic whites to have less than a ninth-grade education. Men are more likely than women to be employed in the civilian labor force, and these workers are concentrated in managerial and professional specialty occupations (*Humes & McKinnon, 2000*).

Black/African American

Blacks make up about 13% of the US population. They live primarily in the South (55%), with 19% in the Northeast, 18% in the Midwest, and 8% in the West. Blacks are

likely to be younger than non-Hispanic whites and have larger families. Compared to non-Hispanic whites, blacks experience higher unemployment and hold fewer managerial and professional positions, and married-couple families are less likely to have an annual income of \$50,000 or more than similar non-Hispanic white families (*McKinnon & Humes, 2000*). Because the 2000 census refers to African Americans as blacks, this workbook also uses the term *black* to describe this racial group.

Hispanic

People who identify themselves as Hispanic are members of an ethnic group and may be of any race. Also, the Hispanic population includes many distinct groups that differ in socioeconomic characteristics, culture, and recency of immigration. Hispanic countries of origin identified on the 2000 census include 66.1% from Mexico, 14.5% from Central and South America, 9% from Puerto Rico, 6.4% from other Hispanic countries, and 4% from Cuba. In 2000, 12% of the total United States population was Latino, which represents 32.8 million people (*Therrien & Ramirez, 2001*). Hispanics in the US live in more geographically concentrated areas than non-Hispanic whites. They are more likely to live inside central cities of metropolitan areas, be less than 18 years of age, live in family households that are larger than those of non-Hispanic whites, have different occupational distributions, earn less than white workers, and live in poverty. About 65% of Hispanic elementary and high school students have a foreign-born parent. The uninsured rate declined significantly in 1999 for Hispanics (*Mills, 2000*).

White non-Hispanic

White non-Hispanics represent the largest racial group in the United States (*US Census Bureau, 2001*). In March 1999, whites had the lowest unemployment rates, although their unemployment rates were not statistically different from those of Asian and Pacific Islanders. In 1995, white households had significantly higher levels of median net worth than households identified as black or Hispanic (*Davern & Fisher, 2001*). Records indicate that in 1994, the average number of whites receiving public assistance exceeded the number of blacks by more than 50% (*US Census, 1999*). Whites were more likely to be homeowners (*US Census, 1999*). Almost 25% of white, non-Hispanic adolescents lived with a single mother or father in 1998 (*May Kay, Fingerhut, & Duran, 2000*).

Health care access

Although many adolescents are healthy, millions experience a variety of concerns related to their health during the teenage years. This situation is particularly relevant for select groups of adolescents, especially immigrants and migrant youth. Health insurance coverage is important for these special groups of adolescents because of its close association with health status. Adolescents without health insurance coverage have limited access to care and certainly under-utilize the health care system (*English,*

Morreale, & Stinnett, 1999). State child health insurance programs (CHIPs) are designed to meet the needs of these young people.

CHIP enrollment could increase the care that American Indians already receive. Unfortunately, most health facilities are very far from their residences, and routine care is compromised by constraints on keeping regular appointments. For American Indians, a CHIP must be described as a supplement to, not a replacement for, the type of health care they have been practicing for years within their tribes. Working with the tribal council could ensure that programs are designed to meet specific needs (*University of California, Los Angeles, 2000*).

For Asian and Pacific Islanders, accessing health care is complicated by a lack of familiarity with the US health care system and decreasing resources for community-based health care services. Their employers are less likely to provide health insurance and their low-income population rates are rising compared to other minority groups. CHIP enrollment is compromised by immigration status, fear of foreign systems, general distrust of the government, stigma associated with Medicaid and its former attachment to welfare, and linguistic difficulties (*AMA, 2001*).

Gaps in employer-based health care coverage place uninsured blacks at one and one half times the rate for whites. Among uninsured black children, 20% of school-age children and 10% of younger children have not seen a physician even once in the past year (*Kaiser, 2000*). Because many black families qualify for CHIP enrollment, outreach to these families is critical. However, like other groups, blacks reject the stigma of accepting assistance. Families who understand the connection between taxes and CHIP programs may be more inclined to enroll (*AMA, 2001*).

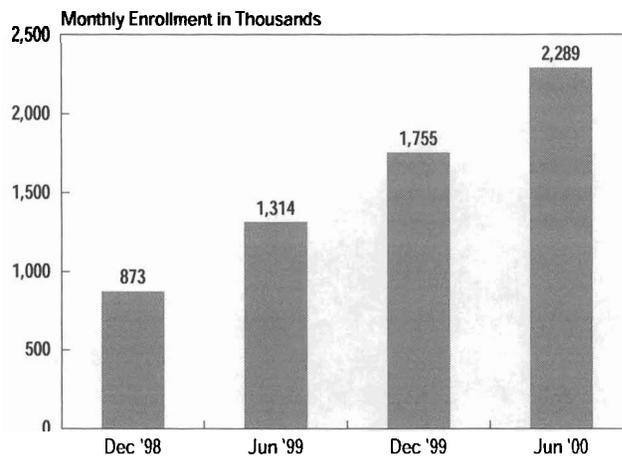
Nearly a third of all Latinos work for an employer who does not offer insurance to any workers. Parents may qualify for Medicaid but often at eligibility levels that are lower than for their children. Although about 85% are US citizens or legal residents, they may be reluctant to apply for Medicaid because they incorrectly fear it will jeopardize future citizenship or they will have to repay the costs of health care received. Cultural and language differences are significant factors that reduce access to care for Latinos who are less likely to have a usual source of care (*Kaiser, 2000*).

The diversity of the Hispanic population necessitates more than one approach to CHIP information, education, and enrollment programs. Although lack of knowledge about CHIP is a great deterrent to enrollment, most Hispanics do not want to be associated with a welfare type of program. Some Hispanics fear that the disclosure of CHIP required enrollment information may expose them to deportation, and others are concerned about CHIP restrictions on practicing traditional medicine. Hispanics want to receive information about the advantages of CHIP from a person they trust and respect.

In 1998, 8% of whites were considered poor, and the child poverty rate, which is always higher than the total poverty rate, was 11% (*Population Profile, 2001*). This was the lowest poverty rate for whites since 1979 (*Dalaker & Proctor, 2000*). Although the poor and near poor are less likely to have health insurance, the uninsured rate declined significantly for whites in 1999 (*Mills, 2000*).

In June 2000, state CHIPs enrolled 2,289,313 children in 49 states and the District of Columbia. This was an annual increase of 975,590 children from the 1,313,723 enrolled in June 1999, or a 74% increase in total CHIP enrollment for the year ending in June 2000. The following chart illustrates CHIP enrollment (*Smith, 2001*).

Total U.S. CHIP Enrollment



Note: As of June 2000, 49 States and the District of Columbia had implemented CHIP Programs. CHIP was implemented in Hawaii in July, 2000.

Source: Compiled by Health Management Associates from state enrollment reports. Smith VK. CHIP Program Enrollment: June 2000. Washington DC: The Henry J. Kaiser Family Foundation, Commission on Medicaid and the Uninsured; January 2001.

Family structure and dynamics

Cultural affiliations can have a strong influence on determining family structure and dynamics. These affiliations include socioeconomic status, educational attainment, race, ethnicity, and communities where families live. Family interactions can make a significant impact on the treatment of health problems and concerns and, in turn, can influence adolescent relationships with physicians. When assessing an adolescent patient's family interactions, think about answers to the following questions.

- Which family members are included in major health-related decisions and how do they make these decisions?

- Do non-family members have a significant influence on family decisions? If so, what is their relationship with the adolescent patient?
- How can the acceptability of confidential discussions between physicians and adolescent patients be ensured with family members?
- What social support networks are available through the family?
- How does the family's culture define roles and responsibilities that may influence health?

Health professionals in the United States are trained to establish individual relationships with adolescents by building trust, protecting their right to privacy, and respecting their autonomy. This framework assumes that the adolescent is individuating from the family unit (*Nidorf & Morgan, 1987*). However, physicians need to recognize that this is an implicit cultural belief to which some groups may not subscribe. Because some families' cultural norms embrace assuming collective responsibility for an adolescent's health, these families may expect to be informed of all information pertaining to their child's health.

Culture of Western medicine

Learning how to navigate the health care system can be complicated regardless of a person's cultural background. Patients who may not be familiar with the values and beliefs inherent in Western medicine may be subject to misunderstandings in a system that supports only specific treatment choices. In the US culture, individuals are considered the basis of society and individualism and independence are highly valued. Consequently, Western health care emphasizes individual control over health problems.

Compared to the US, most other societies are more group-oriented and emphasize external factors in their views of health and disease. For example, Asian Americans emphasize the family and country over the individual. Many Hispanic Americans believe in an "external locus of control" for many life events, and individuals have limited ability to control these events. Members of some racial and ethnic groups may experience the fundamental assumptions of the US medical system as dehumanizing.

In the United States, medical problems fit into academic or other culturally prescribed, isolated categories. Diseases are conceptualized as having discrete causes that are usually biologic, behavioral, or environmental. Adolescent health emphasizes biopsychological causes of disease. Other societies consider the basis for health and illness more broadly. For example, health problems may be related to misfortunes in life or to imbalances in spiritual or supernatural forces, and treatment may incorporate religion or other spiritual references. Some American Indians believe that maintaining a respect for the earth and a balance with all living things is closely linked to an individual's personal health.

Western medicine assumes that patients use only one system of medical care. However, in many parts of the world, health care providers begin their assessment by inquiring about other treatments their patients are using concurrent with biomedicine. Various folk systems continue to be available in the US because they are familiar, consistent with cultural beliefs, low in cost, accessible, and lacking in intrusive testing. For example, some low-income, rural African Americans with limited access to medical care continue to use folk practices.

Rather than the system adapting to the patient, Western medicine views the patient as needing to fit the system. Culturally effective health care, however, requires consideration of the patient's perspective and needs. For example, a model of delivery of mental health services to American Indians includes provision of services at the person's home (*Kavanach & Kennedy, 1992*).

Culture's influence on health care

Culture includes a wide range of experiences, beliefs, and practices that are shared by people who identify themselves as members of a particular group. Although most people are not consciously aware of it, all people have a culture that guides their thoughts and behaviors in various ways.

Most people learn cultural beliefs, values, and practices from their families. Adult family members pass on obvious aspects of culture, including language, customs, and rituals, in addition to conveying implicit assumptions about values and social relationships that usually have a subtle influence on their children's lives. Experiences with other cultural groups and social institutions later in life are also incorporated into people's cultural background and values (*Davis & Voegtle, 1994*).

Culture provides a powerful framework for understanding the world because it outlines a comprehensive system of beliefs and behaviors. Culture facilitates interactions among persons from the same educational, socioeconomic, family, racial, and ethnic culture because they share expectations and beliefs. Conversely, beliefs and behaviors may hinder understanding between culturally different persons.

Culture can affect healthcare in an indirect manner by influencing the physician-patient relationship. For instance, language differences can limit understanding and communication. Misunderstandings and misperceptions can result if physicians and patients from different cultures misjudge each other's actions on the basis of their own unique history. Also, culturally prescribed patterns of communication, etiquette, and problem solving may also result in misunderstandings between physicians and patients (*Kreier, 1999*).

Most people live in multiple cultures today. Adolescents whose parents are first-generation immigrants may have a home culture that differs from their culture at school and from the culture portrayed by the media. For many adolescents, their peer culture differs from that of the adult world.

Health beliefs and practices

Beliefs and practices vary significantly among groups with different racial, ethnic, socioeconomic, and educational backgrounds. Differences include beliefs about the causes of illness and treatment effectiveness, actions required to maintain health and treat illnesses, nutritional practices, and the use of healers or healing systems. Consider assessing these aspects of adolescent health beliefs and practices.

- Actions taken to maintain health
- Eating habits and food preferences
- Treatment for previous illnesses, especially the use of folk and traditional remedies

Talking to people who are familiar with adolescent patients' cultures can provide information about common health beliefs and practices of particular ethnic groups. Consult this workbook's resource section for other pertinent materials. However, please use this information only as a supplement to assessing all adolescent patients individually to determine the extent to which they subscribe to socioeconomic, racial, or ethnically based health beliefs or practices.

As the US population becomes increasingly diverse, racial and ethnic cultural differences between health care providers and their patients will also become more commonplace. Health care providers working with children may be accustomed to issues unique to adolescents; however, differences related to culture may pose challenges that are less familiar and yet have broad and complex implications for health care.

Summary

Health beliefs and practices are closely linked to patients' cultural background. Appreciating the many factors that contribute to patients' culture requires the acquisition of information about their socioeconomic, educational, family, ethnic, and racial background in addition to other relevant information. Some of this information is available through government documents, research studies, and advocacy organizations, while specific information is best obtained through patient interview and observation. Providing health care that is sensitive to adolescents' cultural backgrounds can be very rewarding for physicians who encounter patients who may be less familiar with the system of Western medicine.

Exercises

1. What do you ask adolescents about their socioeconomic status, education, family structure, race, and ethnicity?

2. Has the racial, ethnic, socioeconomic, education, and family structure of your adolescent patients' lives changed in the past few years?

3. How do you anticipate these changes will continue in the next few years?

4. How do you plan to accommodate these changes and better meet adolescent patients' needs?

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Chapter 2

Adolescent Development

The adolescent period of growth and development features a number of unique characteristics. These characteristics are physical, cognitive, psychosocial, and sexual, are bounded by an age range, and include peer and family relationships. When thinking about patients who are between the ages of 10 and 21 years, three distinct categories of early, middle, and late adolescence can be considered. The table on the next page describes characteristics of the dominant US culture. Because most young people are interested in assimilating to the dominant culture, these characteristics can be used as a basis of comparison for assessing growth and development for adolescent patients.

Objectives

1. Review adolescent growth and development
2. Outline adolescent developmental tasks
3. Describe the process of ethnic identification

Growth and development

Characteristics of Early, Middle, and Late Adolescence			
Characteristics	Early Adolescence	Middle Adolescence	Late Adolescence
Growth	<ul style="list-style-type: none"> Secondary sexual characteristics have begun to appear. <p>Growth rapidly accelerating; reaches peak velocity.</p>	<ul style="list-style-type: none"> Secondary sexual characteristics well advanced. Growth accelerating; stature reaches 95% of adult height. 	<ul style="list-style-type: none"> Physically mature; statural and reproductive growth virtually complete.
Cognition	<ul style="list-style-type: none"> Concrete thought dominant. Existential orientation. Cannot perceive long-range implications of current decisions and acts. 	<ul style="list-style-type: none"> Rapidly gaining competence in abstract thought. Capable of perceiving future implications of current acts and decisions but variably applied. Reverts to concrete operations under stress. 	<ul style="list-style-type: none"> Established abstract thought processes. Future-oriented. Capable of perceiving and acting on long-range options.
Psychological Self	<ul style="list-style-type: none"> Preoccupation with rapid body change. Former body image disrupted. Hips widen. Skin and hair become more oily. Pimples may appear. Underarm hair grows. Appetite and nutrition needs change. 	<ul style="list-style-type: none"> Reestablishes body image as growth decelerates and stabilizes. Preoccupation with fantasy and idealism in exploring expanded cognition and future options. <p>Development of a sense of omnipotence and invincibility.</p>	<ul style="list-style-type: none"> Emancipation completed. Intellectual and functional identity established. May experience "crisis of 21" when facing social demands for autonomy.
Family	<ul style="list-style-type: none"> Defining independence-dependence boundaries. No major conflicts over parental control. 	<ul style="list-style-type: none"> Major conflicts over control. Struggle for emancipation. 	<ul style="list-style-type: none"> Transposition of child dependency relationship to the adult-adult model.
Peer Group	<ul style="list-style-type: none"> Seeks peer situation to counter instability generated by rapid change. <p>Compares own normality and acceptance with same-sex age mates.</p>	<ul style="list-style-type: none"> Strong need for identification to affirm self-image. Looks to peer group to define behavioral code during emancipation process. 	<ul style="list-style-type: none"> Recedes in importance in favor of individual friendships.

Characteristics of Early, Middle, and Late Adolescence (continued)

Characteristics	Early Adolescence	Middle Adolescence	Late Adolescence
Sexuality	<ul style="list-style-type: none"> • Self-exploration and evaluation. • Limited caring. Limited intimacy. 	<ul style="list-style-type: none"> • Multiple plural relationships. • Heightened sexual activity. • Testing ability to attract opposite sex and parameters of masculinity and femininity. Preoccupation with romantic fantasy. 	<ul style="list-style-type: none"> • Forms stable relationships. • Capable of mutuality and reciprocity in caring for another rather than former narcissistic orientation. • Plans for future in thinking of marriage, family. • Intimacy involves commitment rather than exploration and romanticism.
Age Range	<ul style="list-style-type: none"> • Initiates between ages 11 and 13 and merges with middle adolescence at 14- 15 years. 	<ul style="list-style-type: none"> • Begins around 14- 15 years and blends into late adolescence around age 17. 	<ul style="list-style-type: none"> • Approximately 17- 21 years; upper end particularly variable; dependent on cultural, economic, and educational factors.

(Hoffmann, 1997)

Developmental tasks

A recent synthesis of adolescent research includes an expanded view of adolescent developmental tasks. The following table lists 10 descriptions of adolescent tasks. The information included in this table provides another perspective on the complex dimensions of adolescent behavior.

The Ten Tasks of Adolescents
1. Adjust to sexually maturing bodies and feelings.
2. Develop and apply abstract thinking skills.
3. Develop and apply a more complex level of perspective taking.
4. Develop and apply new coping skills in areas such as decision making, problem solving, and conflict resolution.
5. Identify meaningful moral standards, values, and belief systems.
6. Understand and express more complex emotional experiences.
7. Form friendships that are mutually close and supportive.
8. Establish key aspects of identity.
9. Meet the demands of increasingly mature roles and responsibilities.
10. Renegotiate relationships with adults in parenting roles.

(Simpson, 2001)

Risk and protective factors in adolescents' lives

Some population groups in the US are at increased risk for health disparities. These disparities can be the result of differences in risk factors, lack of access to health care, lack of effective prevention messages, and cultural differences between the health care system and the population it serves (*US Department of Health and Human Services, Health Resources and Services Administration, 2000*). Because socioeconomic status, race, and ethnicity can be closely intertwined, physicians may experience difficulty separating racial and ethnic disparities from disparities that result from socioeconomic differences (*Fiscella, et al, 2000*). Although all factors that contribute to a young person's culture require consideration, making assumptions about a patient's personal situation can contribute to misunderstandings.

In a recent analysis of factors that influence adolescent risk and protective factors, race, ethnicity, family structure, and income were analyzed as contextual aspects of adolescents' lives. Although risk and protective factors appear to mirror one another, many young people from apparently high-risk situations do not participate in behaviors that compromise their health, while many others in apparently low-risk situations participate in high-risk behaviors. Major conclusions identify school failure as a public health problem, unstructured leisure time spent with friends who participate in specific risk behaviors as having health consequences, and the association of friends' drinking behavior with a number of health problems. "The presence of a positive parent-family relationship" was identified as a consistent protective factor in this study (*Blum, Beuhring, & Rinehart, 2000, p 36*).

Increasing numbers of adolescents are assimilating to the majority US culture from another culture that may emphasize strong ethnic, religious, racial, socioeconomic, or educational affiliations. As these young people move farther away from their cultural roots to embrace the dominant US youth culture, they are more likely to engage in risk behaviors that compromise their health status. Current information from the Youth Risk Behavior Survey (YRBS) is included in the Appendix. The YRBS features self-reported behaviors from high school students across the United States.

Dimensions of cultural identification

Identity formation is one of the areas of adolescent development most strongly affected by cultural and socioeconomic factors. Identities develop through a process of comparing oneself to others and internalizing messages received from others about self (*Erikson, 1959*). Developmental theorists suggest that all young people develop personal identities based on their membership in particular ethnic groups (*Phinney, 1989*).

Ethnicity is an important aspect of cultural identity. Forming an ethnic identity is a process that develops over time. The following chart can assist physicians who are interested in understanding how adolescents form an ethnic identity. This information may also be helpful to young people who are living between two cultures.

Identity development

Stages of Ethnic Identity Development	
Age*	Ethnic Identity**
2-16	Relative Unawareness Child or youth recognizes race/ethnic differences, knows what race or ethnicity he/she belongs to, but race or ethnicity has low salience and is not yet an important aspect of life.
5-21	Emerging Awareness Child or youth comes to understand the social significance of race/ethnicity (eg, that race/ethnicity is an important facet of the social order).
9-25	Exploration/Identification Child or youth begins to develop an understanding and appreciation of the personal significance of race/ethnicity in his or her life.
14-25	Commitment Youth develops a positive commitment to membership in an ethnic or racial group(s) and accepts the positive and negative aspects of both his/her own and other groups.
<p>* Age is approximated.</p> <p>** These stages represent an amalgamation of the work of numerous researchers and theorists, including Atkinson, Morten, & Sue, 1997; 1991; Phinney, 1990.</p> <p>(Rodriguez, Cauce, & Wilson, 2001)</p>	

Adolescents may have particular difficulty with race and ethnicity. Some families in the US find maintaining a traditional family structure almost impossible. Children, especially adolescents, acculturate so quickly to mainstream society through peer experiences at school that family conflict may arise when traditional customs, behaviors, and values differ from the dominant culture (Nakamura, 1998).

Assessing adolescents' and families' identification with particular ethnic, racial, socioeconomic, educational, and religious groups is an excellent way to begin interpreting the impact of cultural factors. This type of assessment can provide initial clues about patients' and families' beliefs and practices. Because an adolescent's identification occurs in stages and may change over time, reassessment is necessary. A comprehensive assessment includes the following components.

- Ethnic or racial origin
- Place of birth

- Length of time spent in the United States
Preferred language spoken with family and friends
- Ethnic background of people with whom patient associates
Involvement with social institutions or groups that are affiliated with certain ethnic or religious groups
- Observance of cultural traditions and holidays
- Family educational history/background
- Current and/or past socioeconomic status

Because young people may be influenced by school, home, and peers, physicians should consider the extent to which adolescent patients identify with each group. Young people who are trying to live within multiple cultures may experience difficulty balancing competing values and demands. Adolescents who are totally assimilated into mainstream American culture may reject their family's cultural values.

As the search for personal identity intensifies, some adolescents may engage in emotional explorations that can be challenging for their families. Physicians can help promote healthy adjustment by reinforcing a positive ethnic identity in the following ways:

Convey support and respect for the youth's ethnic and personal identity search.

Acknowledge societal inequities and the existence of societal racism and discrimination as they relate to health problems.

- Assist adolescents in finding positive ways to deal with racism and discrimination through problem solving or identification of resources or advocacy groups.
- Indicate an openness to discuss racial/ethnic differences and correct misperception or misinformation based on stereotypes or negative societal messages.

Ethnic group membership accounts for only one of the many influences on an adolescent's sense of self. Other factors, described in Chapter 1, that contribute to self-descriptors include socioeconomic status, education, and neighborhoods where young people live. Each adolescent has a unique identity that is influenced by personal experiences, achievements, and relationships with family members and other social groups.

Culturally effective health care

Cultural competence is based on a set of knowledge-based and interpersonal skills. Health care that is culturally effective supports physicians' understanding of and interaction with adolescent patients who identify with cultures other than their own. The following chart outlines the knowledge, skills, and abilities that define culturally effective health care.

Knowledge, Skills, & Abilities Essential to Culturally Effective Health Care

Knowledge

- Culture, history, traditions, values, and family systems of patients.
- Impact of race/ethnicity on health status, behavior, attitudes, and values of patients.
- Help-seeking behaviors of patients.
- Roles of language, speech patterns, and communications styles of patient population.
- Resources (eg, agencies, persons, networks) that can be utilized on behalf of patients.
- Recognition of the ways in which professional values may conflict with or accommodate the needs of patients.

Skills

- Personal qualities that reflect genuineness, empathy, warmth, and capacity to respond to a range of possible situations.
- Acceptance of racial/ethnic differences between and among people.
- Understanding of personal values, stereotypes, and biases about one's own and others' race/ethnicity.
- Techniques for learning and adapting to the personal and cultural patterns of patients and their impact on adherence to prescribed treatment regimens.

Abilities

- Communicate accurate information on behalf of patients to their health plans.
- Discuss racial/ethnic differences and issues openly, and in response to culturally-based cues.
- Assess the meaning race/ethnicity has for individual patients.
- Interpret the implications of symptoms as they are expressed by individuals from different cultures.
- Work effectively with an interpreter to interview patients and provide health care.
- Evaluate new techniques, research, and knowledge regarding their applicability in working with your patient population.
- Secure an appropriate level of adherence and/or cooperation with prescribed treatment regimens.

(Tirado, 1998)

Improving health care

Physicians who provide health care to adolescents who identify with various cultures are bridging the cultural gaps between themselves and their patients. These physicians can anticipate improved health outcomes on the basis of the following criteria.

- Communication and understanding lead to improved diagnoses and treatment plans, and the improved patient satisfaction leads to greater compliance with those plans and fewer delays in seeking care.
- Cultural competence allows clinicians to obtain more specific and complete information to make an appropriate diagnosis.
- Cultural competence facilitates the development of treatment plans that are followed by the adolescent patient and supported by the family.
- Cultural competence reduces delays in seeking care and allows for improved use of health services.
- Cultural competence enhances overall communication and the clinical interaction between the patient and the provider.
- Cultural competence enhances the compatibility between Western and traditional cultural health practices (*DHHS, 1998*).

Culturally effective health care has the potential to improve adolescent health because:

- the perception of illness and disease and their causes varies by culture
- diverse belief systems exist related to health, healing, and wellness
- individual preferences affect traditional and nontraditional approaches to health care; patients must overcome personal experiences of biases within health care systems
- health care providers from culturally and linguistically diverse groups are underrepresented in the current health care service delivery system (*Cohen, Goode, 1999*).

Consequently, failure to understand the cultural background of adolescents and their families can contribute to numerous health problems.

Summary

This chapter reviewed aspects of adolescent growth and development with special emphasis on the acquisition of ethnic identity. Assimilation to the dominant American culture on the part of young people who may have been born in another country or who are transitioning from identification with one culture to another is an important aspect of adolescent development. Assimilating to the dominant youth culture in the United States often signals increased participation in risk behaviors. Physicians who want to provide culturally effective health care should consider the many factors that contribute to young people's culture. These factors have a direct impact on physician-patient communication.

Exercises

1. List some significant encounters that you have had with adolescent patients who are struggling to establish their cultural identity.

2. How can you combine the growth and development and development tasks information to enhance your understanding of adolescents' struggle to establish their own ethnic identity?

3. What are some adolescents' and/or families' existing skills or resources that can be tapped to promote healthy behaviors and compliance with a therapeutic regimen?

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Chapter 3

Communicating with Adolescents and Their Families

Communication is an interactive process through which physicians obtain information about a patient's health history. Patient communication is a complex interaction that can be enhanced by a careful interpersonal assessment of the many factors that influence health. Effective communication begins by developing rapport and establishing trust with adolescent patients and their families. Assessing the impact of cultural factors on an adolescent patient's health is an integral aspect of providing effective health care.

Objectives

1. Understand the components of establishing trust with patients
2. Learn to assess cultural factors in a health history
3. Appreciate the dynamics of adolescents' communication with their families

Developing rapport and establishing trust

Patient communication begins with establishing a positive and trusting relationship with adolescent patients and families, and it is the cornerstone of good medical practice. Cultural differences between physicians and their adolescent patients, however, may contribute to a young person's feelings of discomfort or mistrust. Lack of familiarity with a physician or health care setting may reflect previous negative experiences. Overcoming these barriers can help develop rapport, accommodate cultural differences in communication patterns, and address cultural misunderstandings.

Demonstrating respect for individual differences and creating open channels of communication between physicians and patients are two of the most important aspects of establishing trust and rapport. Respect is conveyed when physicians:

- Listen carefully to adolescent patients and family members, especially when they discuss cultural differences that influence their health and health care.
- Affirm the importance of adolescent patients and their family members by asking them questions about their health practices and avoiding assumptions about their cultural background.
- Take adolescent patients' and families' beliefs, ideas, and values into account when developing a management plan that may include requested folk or cultural remedies (*Davis & Voegtle, 1994*).

Facilitating open communication

Open communication is facilitated by physicians who establish themselves as people with whom adolescents can speak comfortably. Physicians should create an atmosphere of working in partnership with adolescent patients and their families to put them at ease and encourage them to talk about themselves and their culture (*Davis & Voegtle, 1994*).

Encouraging communication includes:

- Using a conversational tone
- Recognizing and accepting feelings that accompany health problems
- Sharing your own similar experiences, if appropriate
- Learning which family members can discuss what health issues and respecting those relationships
- Establishing times to meet separately with adolescents and with parents when possible; recognizing that some families may object to confidential discussions with young people
- Reserving judgment about adolescent and family personal behaviors

- Encouraging adolescents and family members to talk about themselves and their cultural backgrounds

Physicians can convey respect by focusing on adolescents' and their parents' personal and cultural strengths rather than emphasizing the deficits in their lives (*Kalyanpur & Rao, 1991*). Centering discussions on adolescent patients' cultural strengths can counter previous experiences with discrimination and empowers young people to deal more effectively with their health problems and with the health care system.

Variability within cultural groups

Both ethnicity and race are often inappropriately considered the exclusive determinant of one's cultural background. Ethnicity emphasizes common origins, beliefs, and behaviors that form one part of people's cultural background. However, while members of an ethnic group share some elements of a common culture, individuals within that ethnic group may also exhibit different values, beliefs, or practices on the basis of their educational level, income, geographic residence, age, occupation, identification with other groups, or individual experiences. Additionally, a person's country of origin and length of time spent there contribute to differences in ethnic identification.

Within-group variability challenges assumptions about people that are based on race. Reports of both racial and ethnic background may vary depending on whether patients themselves are reporting this information or others are classifying them (*US Department of Health and Human Services, 1993*). Therefore, making assumptions about adolescent patients' and their families' cultural background solely on the basis of race or ethnicity are likely to be stereotypic at best and of little value to improving health care.

Accommodating differences in communication patterns

A positive relationship with adolescents and their families can be established by recognizing and accommodating differences in communication patterns resulting from cultural customs. Both verbal and nonverbal styles of communication may differ among cultures. To avoid misunderstandings or unintentional signs of disrespect, physicians should recognize potential language barriers and obtain information about patient and family communication customs.

Variation in communication customs may result from any of the following situations.

- Etiquette rules include specific ways to greet others, whom to address, and what form of address to use. Some cultures designate a spokesperson on the basis of gender and generational roles. Failure to direct communication to this person might embarrass the person and family members.

- Some conversation topics may be taboo for certain people, such as a man asking a woman questions regarding childbirth or sexuality.
- Communicating emotions varies by culture. People affiliated with cultures that place a high value on emotional restraint and politeness may not communicate their disagreement or hostility. For these people, a smile or “yes” may actually indicate an unwillingness to be disrespectful or impolite and not signal compliance with a physician.
- Silence, physical distance, eye contact, and body movements or gestures are conversational aspects that vary among different groups of people. Some people do not speak while others are talking and they tolerate long periods of silence after another person finishes speaking. Other people consider it appropriate behavior to speak before another person has finished talking and may even consider their interjections a way to affirm interest in a speaker’s message. Some people consider making direct eye contact disrespectful or a sign of hostility, while others regard this behavior as a sign of attentiveness. People regard physical distances very differently; some people are comfortable with close body space during conversations and others prefer greater physical distance (*Randall-David, 1989*).

Communication customs are difficult to assess through direct questioning. Physicians should learn about their patients’ and families’ preferred communication style to avoid misunderstandings.

Assessing cultural factors within a health history

Integrating adolescent patients’ cultural backgrounds into general health assessments and history taking can help physicians understand their patients and facilitate communication. Physicians should consider asking adolescent patients about the significance of their behavior within the context of their cultural background and avoid assessing their patients on the basis of the norms of the dominant culture.

Critical factors to assess include:

- Socioeconomic influences
- Educational attainment
- Family structure and dynamics
- Cultural beliefs and practices
- Ethnic origin and identification
- Language preference

Addressing these issues enhances communication because the assessment encourages physician appreciation for the cultural factors that have an impact on adolescent health problems. All new patients should receive this assessment during intake interviews (Davis & Voegtle, 1994).

Understanding adolescents' perspectives on their health problems

Adolescents may view their health issues very differently from physicians because they do not share the same cultural background. Understanding health problems and behaviors from the perspective of patients and their families is critical to communication. The following questions can help physicians identify an adolescent patient's perspective on a specific presenting problem in an open and nonjudgmental way. The answers to these questions could also be useful in developing a management plan for a particular problem with a long-term patient.

1. How would you describe the problem that has brought you to me?
2. Why do you think this problem has happened to you?
3. What name do you give your problem?
4. What do you think will help treat your health problem?
5. Are there things that make you feel better that doctors do not know about?
6. What do you fear most about your illness or problem?
7. Apart from me, who else do you think can help you get better?
8. Has anyone else helped you with this problem?
 - a) What did this person say was wrong with you?
 - b) What did the person say you should do for this problem?
 - c) Do you agree?
 - d) Did you try it?
9. What are the chief problems your illness has caused you or your family?

(Rios & Simpson, 1998; Nidorf & Morgan, 1987; Kleinman et al, 1978)

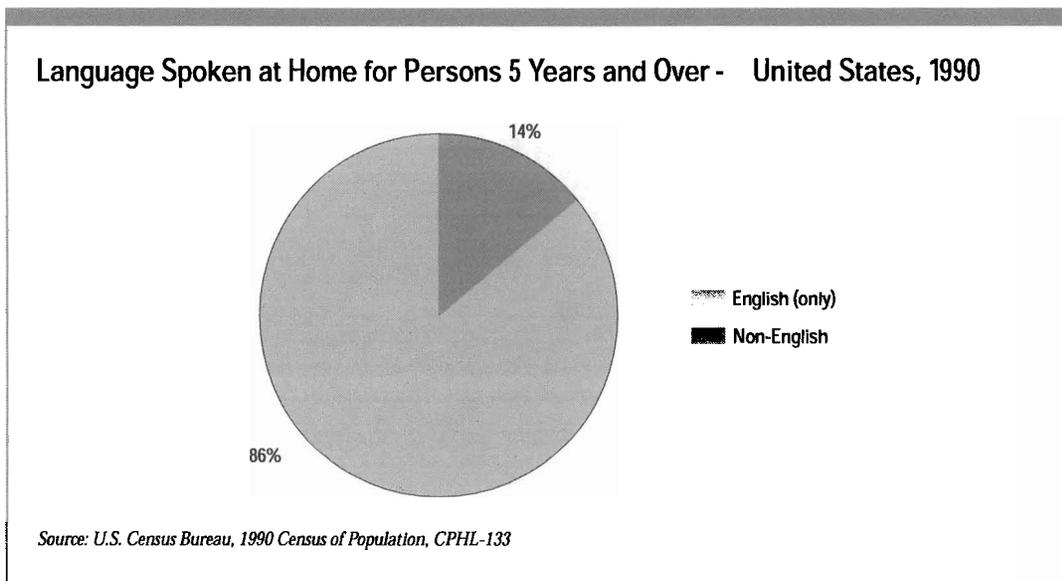
Although the answers to these questions are informative, they constitute a brief, focused overview. Please remember that it is always preferable to obtain a comprehensive health history.

Assessing language preference

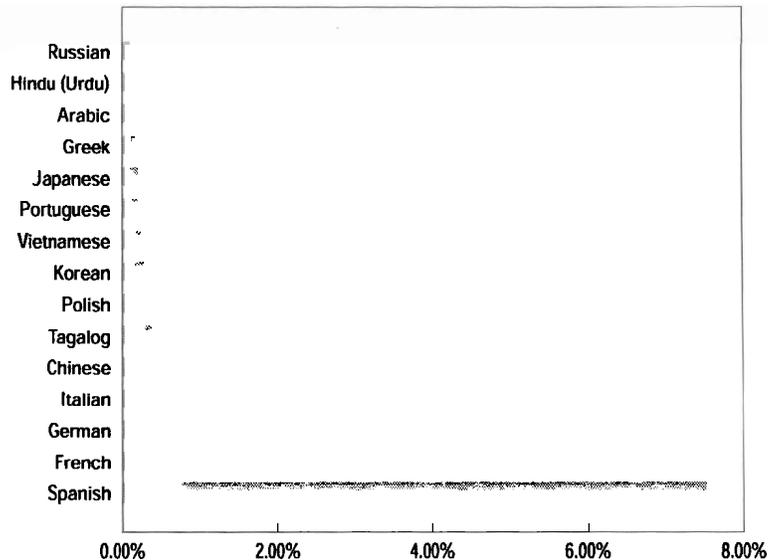
Language preference is important to assess because it can enhance communication and help avoid misunderstandings. If the language differences between physicians and adolescent patients are significant, an interpreter should be included in the conversation. (Refer to Chapter 5 for more information about using interpreters). Patients who do not speak English as a primary language may have difficulty discussing complex health problems. Consider the following issues when determining the necessity for an interpreter.

- Language preference of adolescent and family when discussing health issues
- Language preference for discussion of emotional or sensitive topics
- Language preference for reading and writing

The following charts identify languages spoken in the US as of 1990. Check the 2000 Census Web site for more recent language data when it is available.



Top 15 Non-English Languages Spoken at Home for Persons 5 Years and Over - United States, 1990



Source: U.S. Census Bureau, 1990 Census of Population, CPHL-133.

Recognizing cultural misunderstandings

Acknowledging and addressing cultural misunderstandings, if they occur, facilitates open communication between physicians and adolescent patients. Working with adolescents and their families who represent various racial, ethnic, and socioeconomic groups may occasionally result in misunderstandings. When adolescent patients or their family members seem distant at times, physicians may feel uncertain whether they are communicating effectively. Gentle probing can help physicians discover if they inadvertently violated a communication custom or failed to take cultural beliefs into account. The following recommendations describe ways to restore an effective working relationship with adolescents and family members if misunderstandings occur (Kavanagh & Kennedy, 1992; Pedersen, 1988).

- Be direct and apologize for the behavior that may have distanced the patient or family member.
- Explain how the behavior is appropriate in the physician's culture as a way to provide a rationale for the behavior.

- Acknowledge that the patient and family members know more about their own cultural background than the physician. Ask about ways to generate appropriate and acceptable solutions. This can affirm the physician's commitment to learn about and respect the patient's cultural background.
- Complex situations with unclear solutions may necessitate bringing in an additional person or persons to mediate or act as a "culture broker."

Summary

This chapter outlines the complexities of communicating with adolescent patients and their families who may not share their physician's cultural background. Applying sound communication principles, incorporating an interpreter's skilled assistance, and addressing communication misunderstandings in an open and honest manner can help physicians establish rapport with adolescent patients from a variety of cultural backgrounds. Accommodating language preferences and respecting communication patterns are the foundation of taking an accurate health history.

Exercises

1. List five examples of Western culture that could be changed in the office where you treat adolescent patients to reflect other cultures. Consider posters, magazines, and small decorative items. Keep in mind specific racial and ethnic populations.

2. List instances that you have observed or in which you participated that resulted in medical misunderstandings due to cultural expectations. What could have improved the outcomes of these situations?

3. What is your personal definition of culturally effective adolescent health care?

4. Identify three to five ways in which you can avoid patient miscommunication that results from cultural misunderstandings.

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Chapter 4

Determining Cultural Effectiveness

Cultural backgrounds influence the ways in which people think about things and interact with others. However, acknowledging one's own cultural background can be easily overlooked when developing cultural skills and competencies. Self-assessment can enhance appreciation for and understanding of the multiple cultural influences that shape day-to-day behavior, especially physicians' interactions with their adolescent patients.

Objectives

1. Assess personal cultural background and skills
2. Complete assessment inventories
3. Reflect on formative experiences that shaped personal culture

Physician self-assessment

Many people are unaware of the extent to which their cultural background influences daily interactions, decisions, and judgments about what they value and consider appropriate behavior. Conventional elements of a culture exert a powerful influence on behavior and are accepted implicitly; however, they are seldom discussed explicitly. The implicit process by which culture guides people's thoughts and actions results in assumptions that most people think, feel, and act the same way. Individuals typically become aware of these assumptions only when they encounter an interpersonal conflict that is based on cultural differences.

Physicians may choose to assess their cultural backgrounds in a group setting because it offers the advantage of gaining awareness about both similarities and differences between themselves and others. Some professional organizations, state departments of health, or local human relations offices provide training workshops that address cultural issues (*Davis & Voegtle, 1994*). Consult this workbook's Resource Organizations section to obtain additional materials from medical, ethnic, racial, and governmental organizations that can provide publications to enhance skills through continuing education, print, and/or Internet-based information.

The following exercises are designed to assist physicians in the skills assessment process by asking questions related to cultural values, cultural background, and experiences with other cultural groups, and providing a checklist.

Cultural values in the United States

Physicians can begin the self-assessment process by comparing their beliefs and values with those of another population group. The first exercise includes 15 cultural values and orientations that reflect the European influence on US culture (*Locke, 1992*). The second exercise is an inventory of experiences that shape personal values. The third exercise asks about formative life experiences with other groups. The fourth exercise features a checklist that inventories patient interactions. Optional exercises encourage thoughtful reflection and consideration of sharing insights with colleagues.

Exercise 1

First, read the descriptions of each value at the end of the checklist. Next, decide the extent to which each item represents a value for you by checking one of the yes, no, maybe, or don't know categories. Then, identify the sources of your personal values. When completing this category, consider the formative experiences that shaped the values that your family strongly endorsed and whether these are still values in your current family structure. Values are shaped by identification with the majority culture, education, personal experiences, and exposure to other cultures.

Rating Your Values: Their Importance and Source

	Yes	No	Don't Know	Maybe	Source
Achievement and Success					
Activity and Work					
Democracy					
Efficiency and Practicality					
Equality					
External Conformity					
Freedom					
Humanitarian Mores					
Individual Personality					
Material Comfort					
Moral Orientation					
Nationalism-Patriotism					
Progress					
Racism and Related Group Superiority					
and Secular Rationality					

Rating Your Values: Their Importance and Source *(continued)*

Definitions

Achievement and success: These include an emphasis on financial success and the importance of recognition for one's achievements.

Activity and work: Disciplined, productive activity is considered a worthy end in itself.

Democracy: This is a belief that every person should have a voice in the country's political destiny.

Efficiency and practicality: The practical value of getting things done is stressed.

Equality: Equality of opportunity is emphasized.

External conformity: Value includes uniformity of dress, housing, verbal expression, manners, and political ideas. Deviance from norms is discouraged.

Freedom: Individual freedom and opposition to constraints on freedoms are included.

Humanitarian mores: Coming to the aid of others and traditional sympathy for the "underdog" are hallmarks of humanitarianism.

Individual personality: Every individual should be independent, responsible, and self-respecting. The group should not take precedence over the individual.

Material comfort: The "good life" includes conspicuous consumption of material goods.

Moral orientation: Life events and situations are judged in terms of right and wrong.

Nationalism-patriotism: A strong sense of loyalty is considered "American."

Progress: This value emphasizes an optimistic belief that, over time, life for all is getting better.

Racism and related group superiority: Differential evaluation of racial, religious, and ethnic groups is emphasized.

Science and secular rationality: Sciences are esteemed a means of gaining knowledge and of asserting mastery over the environment.

(Davis & Voegtli, 1994)

If you are completing this exercise with a group of colleagues or using it as a teaching tool, you may wish to consider some additional uses for it. For instance, you can discuss how people rank the values that they consider most and least important. Another discussion can feature consideration of values that were accepted and rejected during people's own adolescence. Other considerations can focus on how differences in cultural values may influence the relationships between physicians and their adolescent patients.

Your own cultural background

Each person's cultural background includes many influences that form a unique constellation of personal values. Beliefs, behaviors, and practices reflect personal associations with several groups including an ethnic group, socioeconomic class, religious organization, age group, and social or community group. Some of these associations may have changed over time.

Exercise 2

This exercise is actually an inventory that asks about experiences included in four major categories that influence value development. These categories include religion, socioeconomic status, ethnic affiliation, and other influences. Begin by reviewing the entire list. Next, select groups within each category with which you most strongly identify. Then, describe the values or practices associated with each group. You may wish to consider how the strongest affiliations defined family roles, communication styles, taboo or avoided discussion topics, health practices or beliefs, and attitudes about illness, death, and sexuality. Give particular consideration to the ways in which your family dealt with disease.

Religious Affiliation

Affiliation of family of origin _____

Religious group with which you identify _____

What values or practices do you associate with your religious affiliation?

What changes have you made in your religious affiliation?

Socioeconomic Class

Socioeconomic class of family of origin _____

Your own socioeconomic class _____

What values or practices do you associate with your socioeconomic group?

What changes have you made in your socioeconomic class?

Ethnic Group (may overlap with religious affiliation)

Ethnic group of family of origin _____

Ethnic group with which you identify _____

What values or practices do you associate with your ethnic group?

What changes have you made in your ethnic group?

Other Group Identifications (community, special interest, etc)

Other family-of-origin group identifications _____

Other groups with which you identify _____

What values or practices do you associate with these groups?

What changes have you made in the groups with which you identify?

Have you had to resolve conflicts between the values or practices of different groups with which you associate? If so, how have you resolved these conflicts?

Which family-of-origin values or practices of your family have you retained?

Which have you changed?

Which family-of-origin values or practices would you most want a child of your own to retain?

(Davis & Voegtle, 1994)

Assessing your experiences with other cultural groups

People form impressions of others who are from different racial or ethnic groups than themselves by direct interactions or indirectly through reading and the media. Interpersonal experiences with people from other cultural groups may exert a powerful influence on physicians' comfort level as they interact with people from backgrounds that differ from their own.

Exercise 3

Consider your early life with respect to school, religion, neighborhood, athletics, or other formative experiences, which may have centered on music, theater, film, or science. Think about the intensity of these experiences as they related to interactions with other cultural groups.

Experience	Intensity		
	Limited	Moderate	Extensive
Early school years			
Religion			
Neighborhood			
Athletics			
Music, theater, film			
Science			
Undergraduate			
Medical school			
Professional life			

List specific situations that created uncertainty or discomfort.

List situations that were enjoyable; include references to food, music, and dancing.

Optional Exercise

This exercise may provide some important information to you and your colleagues. The questions relate to your values and the values of the adolescent patients whom you treat. This exercise is appropriate for consideration in a group teaching/learning situation.

Identify the following information about your adolescent patients.

Ethnic groups: _____

Socioeconomic classes: _____

Religions: _____

Communities: _____

List the ways in which their experiences differ from your own.

List the ways in which their experiences are similar to your own.

Identify how these differences may influence your interactions.

(Davis & Voegtle, 1994)

Promoting cultural diversity and cultural competence

The following checklist was developed by the Georgetown University Child Development Center's National Center for Cultural Competence. The checklist was developed for personnel who provide health services and support to children with special health needs and their families, and it is intended to increase the awareness and sensitivity to the importance of cultural diversity and cultural competence in human service settings. Your responses to the following questions will offer further insight into the health care that you provide to adolescent patients.

Directions

Please select A, B, or C for each item listed below.

A=Things I do frequently

B=Things I do occasionally

C=Things I do rarely or never

Physical Environment, Materials, & Resources

1. I display pictures, posters, artwork, and other decor that reflect the cultures and ethnic backgrounds of clients served by my program or agency.
2. I ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of individuals and families served by my program or agency.
- _____ 3. When using videos, films, or other media resources for health education, treatment, or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families served by my program or agency.
4. I ensure that printed information disseminated by my agency or program takes into account the average literacy levels of individuals and families receiving services.

Communication Styles

5. When interacting with individuals and families who have limited English proficiency, I always keep in mind that:
 - _____ • limitations in English proficiency are in no way a reflection of their level of intellectual functioning.
 - _____ • their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
 - _____ • they may or may not be literate in their language of origin or English.
6. I use bilingual-bicultural staff and/or personnel and volunteers skilled or certified in the provision of medical interpretation during treatment, interventions, meetings, or other events for individuals and families who need or prefer this level of assistance.
7. For individuals and families who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment, or other interventions.
8. I attempt to determine any familial colloquialisms used by individuals or families that may impact on assessment, treatment, or other interventions.
9. When possible, I ensure that all notices and communiqués to individuals and families are written in their language of origin.
10. I understand that it may be necessary to use alternatives to written communications for some individuals and families, as word of mouth may be a preferred method of receiving information.

Values & Attitudes

11. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.
12. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with individuals and families served by my program or agency.

13. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that show cultural insensitivity, racial biases, and prejudice.
- _____ 14. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.
- _____ 15. I understand and accept that family is defined differently by different cultures (eg, extended family members, fictive kin, and godparents).
16. I accept and respect that male-female roles may vary significantly among different cultures and ethnic groups (eg, who makes major decisions for the family).
17. I understand that age and life cycle factors must be considered in interactions with individuals and families (eg, high value placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family).
18. Even though my professional or moral viewpoints may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives.
19. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.
- _____ 20. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease, and death.
- _____ 21. I understand that the perception of health, wellness, and preventive health services have different meanings to different cultural or ethnic groups.
22. I recognize and accept that folk and religious beliefs may influence an individual's or family's reaction and approach to a child born with a disability, or later diagnosed with a disability, genetic disorder, or special health care needs.
23. I understand that grief and bereavement are influenced by culture.
24. I seek information from individuals, families, or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse groups served by my program or agency.

25. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to the culturally and ethnically diverse groups served by my program or agency.
26. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency.
27. I am aware of the socio-economic and environmental risk factors that contribute to the major health problems of culturally, ethnically, and racially diverse populations served by my program or agency.
28. I am well versed in the most current and proven practices, treatments, and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program.
29. I avail myself of professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially, and linguistically diverse groups.
30. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence.

How to use the checklist

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural and linguistic cultural competence in health and human service settings. It provides concrete examples of the kinds of beliefs, attitudes, values, and practices that foster cultural and linguistic competence at the individual or practitioner level. There is no answer key with correct responses. However, if you frequently responded "C", you may not necessarily demonstrate beliefs, attitudes, values, and practices that promote cultural and linguistic competence within health care delivery programs.

Tawara D. Goode- Georgetown University Child Development Center- UAP. Adapted from Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings and Promoting Cultural Competence and Cultural Diversity for Personnel Providing Services and Supports to Children With Special Health Care Needs and Their Families (June 1989; revised 1993; revised February 1996; October 1997; September 1999; July 2000).

Exercise 4

After completing the exercises in this chapter, you may wish to deepen your insights and broaden your perspective by sharing your reflections with a friend or colleague. Compare your responses with those of several other people with whom you believe you share a cultural heritage to determine if you neglected to include some values, behaviors, or expectations or if your responses differ in some significant way. Comparing your responses with those of people from cultural backgrounds that differ from yours may highlight additional aspects of your heritage that are not shared by others or are so subtle that you were not aware of them. This experience may surprise you by highlighting some similarities across cultures. Finally, consider how your personal values and beliefs resemble or differ from those that characterize your profession.

Participating in training programs will allow you to identify your cultural values and beliefs through group interactions. However, if you are unable to do this, please keep this in mind. You can go a long way toward achieving cultural self-awareness by making a strong commitment to continue to explore elements of your cultural background and the ways in which your beliefs might influence your relations with culturally diverse adolescents and their families.

Summary

This chapter includes a number of inventories and assessment instruments that can help physicians consider the development of their own opinions and values. Understanding the development of one's own health behaviors and beliefs can enhance appreciation for patients' health value systems. These exercises are appropriate for both individual and group educational experiences.

References

- Davis BJ, Voegtle KH. *Culturally Competent Health Care for Adolescents*. Chicago, Ill: American Medical Association, Department of Adolescent Health; 1994.
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Chapter 5

Special Issues

The unique context in which health care is provided and received is distinguished by a number of issues that manifest themselves between physicians and patients. These issues can be confounded or enhanced by physicians' understanding of their patients' level of health literacy, the complex relationships among physicians, patients, families, and interpreters, and the availability of physicians from diverse populations to meet the needs of specific racial and ethnic patient groups. These issues are addressed in the chapter.

Objectives

1. Assess health literacy of patients and their families
2. Identify instances in which to include an interpreter
3. Review the importance of physician diversity

Health literacy

Health literacy refers to the ability to read, understand, and act on health information. An estimated 90 million Americans may have problems related to understanding health-related information, especially directions for taking medication. The majority of low-literate Americans are native-born whites, although 50% of Hispanics, 40% of blacks, and 33% of Asians in the United States have literacy problems. The workbook's Resources section includes information on the American Medical Association Foundation's signature program on health literacy, which is designed to increase physicians' awareness of the prevalence of low health literacy and how it influences physician-patient relationships.

Health literacy - things to think about

1. People with low health literacy often have difficulty completing intake information. Consider the intake process in your practice. Where might potential problems arise for one of your patients with low health literacy skills?

Completing medical history forms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Providing insurance information	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Understanding consent forms	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Following signs and directions to your office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Interacting with office staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. What techniques have you employed in your office practice to enhance patient comprehension?

Asking patients to repeat information	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speaking more slowly	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Presenting 2 or 3 concepts at a time and checking for understanding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Using simple language (avoid technical jargon)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reading instructions to patients	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Conducting follow-up calls to check understanding and compliance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Providing patient education materials	<input type="checkbox"/> Yes	<input type="checkbox"/> No

3. What resources are available to help you improve the health care experience for patients with low health literacy?

Office staff	___ Yes	___ No
Patients' family members	___ Yes	___ No
Volunteers	___ Yes	___ No
Community resources	___ Yes	___ No
Office systems	___ Yes	___ No
Publications	___ Yes	___ No

4. As a physician, you have acquired certain skills for discussing difficult situations with your patients (eg, sexual problems, family violence, death and dying). Which of these skills and communication approaches could be helpful for addressing the fear and shame of patients with low health literacy?

(adapted from AMA Health Literacy Physician Feedback Survey)

Several tasks that address adolescent patients' and their families' low health literacy include:

- Offering a shame-free environment
- Using simple language
- Employing non-threatening instructions
- Welcoming family members or friends to assist patients
- Asking patients and/or families to repeat their understanding of medical instructions in a teach-back manner

Using interpreters

Language proficiency should be determined before an adolescent patient visit in which limited English-language skills are identified. For instance, adolescents for whom English is a second language may speak English with reasonable fluency, but may not have sufficient linguistic skills to understand complicated medical information. The expertise of an interpreter may meet the needs of these adolescent patients and their families.

Interpreters can facilitate cross-cultural communication between adolescent patients and physicians who do not speak the same language and meet the needs of those adolescents who require linguistic assistance to understand medical instructions. Although their services are required in some specific situations, the presence of an interpreter can complicate the physician-patient interaction. Interpreters who not only translate the

interaction but also bridge the culture gap between physicians and adolescent patients offer the broadest range of skills. Recommendations for selecting and interacting with interpreters are included in the following sections.

Choosing an interpreter

Interpreter characteristics

- Cross-cultural interpretation training
- Health field training
- Proficient in the patient's language
- Proficient in physician's language
- Ability to understand patients' and their families' culture
- Respect for patients' and their families' culture
- Ability to understand physician's culture and culture of Western medicine
- Respect for physician's culture
- Respect for patients'/parents' culture

Interpreter substitutes

Volunteers can substitute for interpreters if they:

- have medical terminology training
- understand the patient's health problem
- can translate the patient's health problem to the physician
- can apply the principles of confidentiality

Bilingual hospital personnel:

- Use them only if they are trained interpreters

Family members:

- Use cautiously
- Consider their age and gender
- Respect adolescent patients' feelings about discussing intimate matters through a family member interpreter of the opposite sex or with someone younger or older
- Remember that family members may wish to censor what is said to shield the patient or to keep information within the family

Relationships with interpreters

- Adolescent patients should be consulted about the selection of an interpreter to protect their privacy because the interpreter's educational level, age, gender, or relationship with the patient's family can facilitate or inhibit communication.
- Interpreters who are influential leaders in the patient's community may embarrass adolescents and families who need to discuss specific information. Interpreter may act as gatekeeper of information that could benefit the patient if communicated to the physician by omitting or adding information related to premarital sex, birth control, use of medications, and psychosocial problems.

Using an interpreter

- Meet regularly with interpreters to maintain open communication and facilitate an appreciation for patient visit needs for information and understanding.
- Interpreters need to meet with new adolescent patients and their families before an initial scheduled appointment to determine their educational levels, attitudes toward health, and understanding of Western medicine.
- Physicians and interpreters should use short units of speech instead of long, involved sentences or paragraphs. They should avoid long, complex discussions of several topics in a single appointment.
- Physicians should avoid technical terminology, abbreviations, professional jargon, abstractions, idiomatic expressions, slang, similes, and metaphors.
- Interpreters should translate the adolescent patients' and families' own words as much as possible and avoid paraphrasing. Interpreters' goals should include communicating the patients' and families' understanding of what is going on, their emotional state, and other important, relevant information.
- Interpreters should not include their own interpretation of the patient's situation or selectively omit information.
- Interpreters should translate information and repeat back to the physician adolescent patients' and families' verbal understanding of medication and other procedural instructions to check for accuracy and offer an opportunity to correct any misunderstandings.
- Physicians should sit facing their patients with the interpreter sitting at an angle so that they can ask questions directly to the adolescent patient or family member and not speak through the interpreter. This approach communicates warmth and concern through body language, even though the words may not be completely understood.

- Physicians should listen closely and observe facial expressions, voice intonations, and body movements for cues that may aid in the adolescent patient's health assessment.
- Interpreters lengthen the patient visit because careful interpretation often requires long explanatory phrases to ensure accuracy.

Creating an active communication process

Including interpreters in adolescent patient visits does not preclude physicians from actively participating in the communication process. The following recommendations are designed for patients with limited English proficiency.

- Proper forms of address convey respect for adolescents and their families and demonstrates a willingness to learn about their culture.
- Learning some basic words and sentences of the adolescent patients' language and becoming familiar with special terminology that patients use can decrease misunderstandings in the interpreter-patient-parent interchange.
- Physicians can convey interest in adolescent patients and their families through a positive tone of voice rather than appearing condescending, judgmental, or patronizing.
- Physicians need to repeat important information and emphasize the rationale for a treatment or prescription.
- Explanatory information and materials written in the adolescent patients' and families' language can reinforce verbal interaction.

Physicians can avoid misunderstandings and unintentional offenses by observing cross-cultural variations in nonverbal communication. Be aware of silence, physical distance, eye contact, emotional-expressiveness, and body movements (*Randall-David, 1989*).

Diversity in medicine

This workbook provides background information and exercises that are designed to promote delivery of culturally effective health care by physicians whose cultural backgrounds may differ from their patients'. Increasing the number of physicians from diverse cultural backgrounds represents the other side of the equation. Research indicates that many patients feel more comfortable with physicians who are from their own ethnic and cultural background. For example, the findings of one recent study suggest a mismatch between adolescent patients and their health care providers (*Ziv et al, 1999*). Currently, among 797,634 physicians in the United States, 435,847 (55%) are white, 20,552 (2.6%) are African American, 28,290 (3.5%) are Hispanic, 492 (0.06%)

are American Indian or Alaska Native, 72,803 (9.1%) are Asian, and 219,510 have an unknown racial or ethnic determination (AMA, 2001).

During the past three generations, underrepresented minorities (American Indian, African American, Mexican American, mainland Puerto Ricans) have made significant gains in applying and being admitted to medical schools. However, in spite of these increases, minorities still face medical school inequalities. These inequalities are evident when the percentages of underrepresented minorities who apply, attend, or participate as medical school faculty are compared to a population whose diversity continues to increase. A study reported in the *Journal of the American Medical Association (JAMA)* (Barzansky et al, 2000) indicated that the number of Hispanic, African American, and American Indian medical school applicants fell by almost 7%, from 4,487 in 1998 to 4,181 in 1999. In 1999 the US first-year medical school classes were 7.9% African American, 6.9% Hispanic, and 0.7% American Indian.

Decreasing medical school diversity affects both the medical profession and the patients it serves. Greater racial and ethnic diversity among physicians benefit underserved minority populations because the minority identity of a physician is often a marker for future service to minority populations. Physicians from lower socioeconomic backgrounds continue to provide a disproportionate amount of medical services to patients who are minorities, poor, and Medicaid beneficiaries. In addition, minority patients often request physicians who share their racial and ethnic backgrounds. A decreasing number of minority physicians may compromise access to health care for needy patient populations.

Studies similar to those published in *JAMA* make it clear that the medical profession must actively develop and implement strategies to recruit and train under-represented minority students. AMA policies support the expansion of opportunities for minority students who want to pursue careers in the medical profession. The AMA has created a Minority Affairs Consortium that uses its Governing Council and member support to encourage increasing diversity within the medical profession.

Many of the medical and health-related organizations and Web sites that are listed in this workbook's Resources section are working to increase the number of minority physicians within the US workforce. Culturally competent physicians can support the goal of increasing the diversity among physicians and other health care professionals.

Summary

Patient literacy, interpreters, and physician diversity are all issues on the adolescent patient health care landscape. Literacy is an emotional issue for those patients who work hard to compensate for their difficulties. Physicians can accommodate these patients' needs by following a few simple guidelines. Although young people who are new immigrants to the US may quickly acquire English language skills, they typically require translation services to understand medical information. Physicians can avoid patient and family misunderstandings that result from translating information from one language to another by using interpreters. Professionally trained interpreters offer advantages over volunteers and concerned friends, who may experience difficulty maintaining privacy and objectivity. Many patients want to be treated by a physician who shares their ethnic identity or racial heritage. Increasing the diversity in applicants to medical schools can address this need.

References

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- Barzansky B, Jonas HS, Etzel SI. Educational programs in US medical schools, 1999-2000. *JAMA*. 2000;284:1114-1120.
- Randall-David E. *Strategies for Working With Culturally Diverse Communities and Clients*. Bethesda, Md: Association for the Care of Children's Health; 1989.
- Ziv A, Boulet JR, Slap GB. Utilization of physician offices by adolescents in the United States. *Pediatrics*. 1999;104:35-42.

Chapter 6

Making It Happen

Maintaining lasting behavioral change begins with commitment and ends with an evaluation of the outcomes. Making a commitment is the easy part, especially when the issue involves professionalism. However, most commitments are short-lived unless an action plan is developed that outlines the steps required to implement change. Learning to offer culturally effective health care to adolescent patients is similar to making other behavioral changes; it requires information, resources, insight, and dedication. This chapter outlines the components of cultural competence and describes sources of adolescent health information, federal legislation, and a sample action plan.

Objectives

1. Describe data sources that can enhance knowledge base
2. Review federal legislation related to patient care
3. Develop a cultural competence improvement plan

Cultural competence

Competencies represent proficiencies that necessitate knowledge and skill acquisition. Attaining cultural competence requires skills and mastery; however, it is an interactive, interpersonal, ongoing process, not a static experience. This section outlines and defines the components of cultural competence.

Seven domains of cultural competence

1. Values and attitudes

- promoting mutual respect
- awareness of the varying degrees of acculturation
- client-centered perspective
- acceptance that beliefs may influence a patient's response to health, illness, disease, and death

2. Communications styles

- sensitivity
- awareness
- knowledge
- alternatives to written communication

3. Community/consumer participation

- continuous, active involvement of community leaders and members
- involved participants are invested participants and health outcomes improve

4. Physical environment, materials, resources

- culturally and linguistically friendly interior design, pictures, posters, artwork, magazines, brochures, audio, videos, films
- literacy-sensitive print information
- congruence with the culture and the language

5. Policies and procedures

- written policies, procedures, mission statements, goals, objectives incorporating linguistic and cultural principles
- clinical protocols, orientation, community involvement, outreach
- multicultural and multilingual staff that reflects the community

6. Population-based clinical practice

- culturally skilled clinicians avoid misapplication of scientific knowledge
- avoid stereotyping while appreciating the importance of culture
- know their own world views
- learn about populations
- understand sociopolitical influences
- practice appropriate intervention skills and strategies

7. Training and professional development

- requiring training
- nature of cultural competence training
- duration and frequency of professional development opportunities

(US Health Resources and Services Administration, Bureau of Primary Care, 2000)

Adolescent health data resources

Developing cultural competencies is enhanced by the acquisition of information about adolescents and the behaviors that influence their health. Most of the following resources feature national data; however, a few references include state and local information. Physicians can identify local information through existing available data resources and compare it to national data trends to further their knowledge about adolescent behavior.

Adolescent Health Chartbook, Health United States, 2000

The Adolescent Health Chartbook presents national trends and health statistics of the US adolescent population, 10 to 19 years of age, including trend tables and racial and ethnic data. The Chartbook is available at the Health, United States Web site at www.cdc.gov/nchs/products/pubs/pubd/hus/hus.htm.

This publication is produced by the US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics in Hyattsville, Maryland.

America's Children: Key National Indicators of Well-being

The Interagency Forum on Child and Family Statistics prepares this annual report as a collaborative effort by 20 federal agencies. The report offers a comprehensive set of indicators of well-being for America's children and includes eight contextual measures

that describe the changing population, family characteristics, and the context in which US children are living. This report is available at www.childstats.gov.

Children's Defense Fund

Children's Defense Fund offers data related to children at state and national levels. The data allows readers to look at how their own state is doing and what areas need improvements, look at states around them, look at the national average, and then encourage their elected officials (at the federal, state, and local level) to do more for children. The Children's Defense Fund published the *2000 Children in the States* data book, with the 2001 edition to be released in September. The Web site, which can be accessed at www.childrensdefense.org/statesdata.htm provides a map of the US in which the reader can click on a particular state and find important information such as how their state ranks in health insurance coverage, teen births, and firearm deaths. The *2000 Children in the States* or the *2001 Children in the States* data books can be ordered online or by calling 202 662-3652.

Henry J. Kaiser Family Foundation

The Henry J. Kaiser Family Foundation provides an Internet resource that offers current health information for all 50 states, the District of Columbia, and US territories. Data can be accessed from State Health Facts Online at www.statehealthfacts.kff.org, which provides health policy information on a broad range of issues such as managed care, health insurance coverage and the uninsured, Medicaid, Medicare, women's health, minority health, and HIV/AIDS. Users can view information for a single state or compare and rank data across all 50 states and compare it to US totals. Information on more than 200 topics is displayed in tables, rankings, graphs, or color-coded maps, and can be downloaded for customized comparisons.

2000 KIDS COUNT

KIDS COUNT is a product of the Annie E. Casey Foundation, which provides national and state-by-state data on the status of children living in the United States. The annual KIDS COUNT Data Book provides benchmarks of child well-being in the areas of education, social, economic, and physical health. State-level data is also available through specially funded projects that provide detailed data on children and their well-being at the state level. Information on KIDS COUNT is available at the KIDS COUNT Web site at www.kidscount.org. Through the KIDS COUNT online interactive database, users can view graphs, maps, rankings, and state profiles and download raw data.

The National Longitudinal Study of Adolescent Health (Add Health)

The Add Health Survey is a comprehensive school-based study of the health-related behaviors of adolescent in the United States. In the first phase of the study, 90,000 students in grades 7 through 12 in 134 US schools answered brief questionnaires

regarding their health, friendship, self-esteem, and future expectations. During the first phase, administrators at the participating schools also completed questionnaires regarding school policies, teacher characteristics, health service availability, and student body characteristics. The second phase of the study involved 20,000 in-home interviews of students during April and December of 1995 (wave 1) and April and August of 1996 (wave 2). Phase 3 of the survey is planned for 2001 and will involve the entire original sample group. The monograph, *Protecting Teens: Beyond Race, Income and Family Structure*, by Trisha Beuhring, PhD, Robert W. Blum, MD, MPH, PhD, and Peggy Mann Rinehart, was produced using these data with grant support from the Robert Wood Johnson Foundation. Copies of this report are available by contacting Add Health, c/o Center for Adolescent Health, University of Minnesota, 200 Oak St SE, Suite 260, Minneapolis, MN 55455-2002, or by e-mail at aph@umn.edu.

Youth Risk Behavior Surveillance System (YRBS)

The US Youth Risk Behavior Surveillance System (YRBS) monitors six categories of youth and young adult health risk behaviors. These six categories include behaviors that contribute to unintentional and intentional injuries; alcohol and other drug use; tobacco use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs) (including human immunodeficiency virus [HIV] infection); unhealthy dietary behaviors; and physical activity. The Centers for Disease Control and Prevention (CDC) oversees the YRBS school-based surveys that are conducted by education and health agencies. The latest YRBS survey data is available through the *Morbidity and Mortality Weekly Reports (MMWR)* and through their Web site, www.mmwr.gov.

This workbook's Appendix includes current YRBS data.

Federal laws and regulations

Physicians who want to provide culturally effective health care to their adolescent patients should be aware of several laws and regulations that influence their clinical practice. The following list describes selected federal laws, regulations, standards, and guidance related to the provision of culturally competent health care services:

Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda

On January 1, 2000, the Department of Health and Human Services, Office of Minority Health, began a 120-day comment period and regional meetings to address a draft for national standards on culturally and linguistically appropriate health care. A report entitled "Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda," produced by the HHS Office of Minority Health by Resources for Cross Cultural Health Care and the Center for the

Advancement of Health, recommends 14 national standards based on an analytical review of key laws, regulations, contracts, and standards currently used by federal and state agencies.

The 14 draft standards were printed in the December 12, 1999, *Federal Register* with an announcement of the three regional meetings and methods of submitting public comment. The final report was published in late December 2000 and is available at www.omhrc.gov/CLAS (*US Department of Health and Human Services, 2000*).

Revised CLAS standards from the Office of Minority Health

1. Health care organizations should ensure that patients/consumers receive from all staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
 2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
 3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
 4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
 5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
 6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
 7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
 8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
 9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encourages to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
 10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records integrated into the organization's management information systems, and periodically updated.
 11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
 12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
 13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
 14. Health care organizations are encouraged to regularly make available to the public information about the progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.
- Note: The standards are organized by three themes.*
1. *Culturally Competent Care (Standards 1-3)*
 2. *Language Access Services (Standards 4-7)*
 3. *Organizational Supports for Cultural Competence (Standards 8-14)*

Emergency Medical Treatment and Active Labor Act (EMTALA)

The EMTALA was enacted to reduce the practice of “dumping” patients who lack the financial ability to pay for hospital costs. It requires the hospitals with emergency departments that participate in Medicare programs to treat all patients regardless of their ability to pay. Hospital responsibilities stipulated by EMTALA include the diagnosis, informed consent, treatment, and notification of condition and intent to transfer to another medical facility. It also requires that patients be provided with language assistance if they have limited English proficiency.

The American Medical Association Organized Medical Staff section has published “EMTALA Quick Reference Guide for On-Call Physicians.” For more information on this guide contact the AMA, Organized Medical Staff Section, 515 N State St, Chicago, IL 60610.

Guidance on assistance for persons with limited English skills

The US Department of Health and Human Services (HHS) has published guidance outlining the legal responsibilities of health and human service providers who receive federal financial assistance from HHS to ensure language assistance for persons with limited English skills. The guidelines explain how health care providers can comply with Title VI of the 1964 Civil Rights Act, which, among other things, requires that physicians and others who accept federal funding ensure that patients with limited English proficiency can have meaningful access to programs and services. More information is available at www.hhs.gov/ocr.

The Hill-Burton Act

The Hill-Burton Act authorizes assistance to public and other nonprofit medical facilities such as acute care general hospitals, special hospitals, nursing homes, public health centers, and rehabilitation facilities. Facilities receiving funds under the Hill-Burton Act for construction and modernization agree to provide services without discrimination on the basis of race, color, national origin, creed, or other reasons unrelated to the individual’s need for service. A facility receiving Hill-Burton funds may not deny services to persons who are unable to pay for them under the uncompensated services provisions of the Hill-Burton Act (fact sheet from the Office of Civil Rights, US Department of Health and Human Services, Washington, DC www.hhs.gov/ocr/hburton.html).

Medicaid

This is a federal-state cooperative program that provides medical assistance and health insurance to children, adolescents, poor families, disabled persons, and indigent and elderly people. Medicaid providers and participating agencies are required to provide culturally and linguistically appropriate services.

Title VI of The Civil Rights Act of 1964

This is a national law that protects persons from discrimination based on their race, color, or national origin in programs that receive federal financial assistance. Under this law, if you are eligible for health care, public assistance, or other social services, you cannot be denied these benefits because of your race, color or national origin (*Office of Civil Rights Fact Sheet*. www.hhs.gov/ocr/title6.html).

Recommendations for getting started

The end of this workbook is really the beginning for physicians who are interested in meeting the needs of an increasingly diverse adolescent patient population. Getting started is usually the greatest initial challenge. But as the process takes on a life of its own, physicians reap the benefits of experimentation, self-disclosure, insight, discovery, and change. So make a list and get started on one of the most important learning experiences in which you can engage.

- Complete the exercises in each chapter
- Identify information needed to enhance skills
- Discuss interests in cultural effectiveness with colleagues and solicit their support and possible participation
- Establish a timeline for activities
- Collect information about the ethnicity of adolescent patients
- Contact local community groups that are affiliated with adolescent patients
- Visit some of the Web site listed in the Resources section
- Call state medical association to request information about their resources
- Check timeline for progress
- Update personal/professional library with necessary information
- Inquire about local cultural competence training workshops
- Start your own professional support groups to discuss mutual assistance
- Ask adolescent patients for feedback
- Revise timeline to include additional activities
- Assist colleagues who are interested in augmenting their skills
- Offer workshops to interested colleagues

Summary

Integrating a new technique or practice into your clinical interactions with adolescent patients is a process that forms a continuum of initiation, assessment, maintenance, challenges, reassessment, plateaus, and on-going education. For many physicians, getting started can be almost as challenging as maintaining a new interest after the novelty wears off and the real work begins. Providing culturally effective health care is also a process and it requires dedication, openness, personal assessment, flexibility, and professionalism. These physician characteristics can be applied to learning more about adolescent patients' unique backgrounds, their health beliefs and practices, views of Western medicine, and acculturation to the American teen culture. This chapter provides information about adolescent databases, federal regulations, and a getting-started checklist to supplement your efforts. Use the organizations listed in the Resources section to offer assistance and enhance your activities.

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- US Department of Health and Human Services. *Guidance on Assistance for Persons With Limited English Skills*. www.hhs.gov/ocr
- US Department of Health and Human Services, Office of Civil Rights. *Fact Sheet: Hill-Burton Act*. www.hhs.gov/ocr/hburton.html
- US Department of Health and Human Services, Office of Civil Rights. *Fact Sheet: Title VI of the Civil Rights Act of 1964*. www.hhs.gov/ocr/title6.html
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Glossary of Key Terms

Acculturation The change that occurs when two different cultural groups come in contact. In general, the group with the least power is forced to change most but can retain distinctive cultural traits (*Rodriguez et al, 2000*).

Adaptive socialization The combination of proactive and protective messages that, over the course of one's socialization, serve the purpose of affirming one's ethnicity in positive ways, while preparing one for racism and discrimination (*Rodriguez et al, 2000*).

Assimilation The loss of a separate identity and pride in distinctive cultural traits as a result of acculturation (*Rodriguez et al, 2000*).

Culture The thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group (*Cross et al, 1989*).

Cultural competence The knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences, self-awareness, knowledge of the patient's culture, and adaptation of skills (*McManus, 1988*).

Cultural group A group of people who consciously or unconsciously share identifiable values, norms, symbols, and some ways of living that are repeated and transmitted from one generation to another (*HRSA, BPHC, 1996*).

Cultural diversity Differences in race, ethnicity, language, nationality, or religion among various groups within a community; the community is said to be culturally diverse if its residents include members of different groups (*HRSA, BPHC, 1996*).

Culturally and linguistically appropriate services Health care services that are respectful of and responsive to cultural and linguistic needs (*US Department of Health and Human Services, 2000*).

Cultural sensitivity An awareness of the nuances of one's own and other cultures (*HRSA, BPHC, 1996*).

Culturally appropriate Demonstrating both sensitivity to cultural differences and similarities and effectiveness in using cultural symbols to communicate a message (*HRSA, BPHC, 1996*).

Ethnic Belonging to a common group - often linked by race, nationality, and language with a common cultural heritage and/or derivation (*Orlandi et al, 1992*).

Majority or dominant culture The values, beliefs, practices, or symbols shared by the broadest segment of a population and depicted as the norm in the media. In the United States, this usually refers to the culture associated with the white, middle-class population (Davis & Voegtle, 1994).

Minority A group of people who, because of their physical or cultural characteristics, are singled out in their society for differential and unequal treatment and therefore regard themselves as objects of collective discrimination (Giger & Davidhizar, 1991).

Multicultural Designed for or pertaining to two or more distinctive cultures (HRSA, BPHC, 1996).

Race A socially defined population derived from distinguishable physical characteristics that are genetically transmitted (Orlandi et al, 1992).

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Rodriguez J, Cauce A, Wilson L. *A Conceptual Framework of Identity Formation in a Society of Multiple Cultures*. Seattle, Wash: The Casey Family Programs; 2000.

Resource Organizations

American Academy of Child and Adolescent Psychiatry Committee on Ethnic and Cultural Issues
3615 Wisconsin Ave NW
Washington, DC 20016-3007
202 966-7300; fax 202 966-2891
www.aacap.org

American Academy of Family Physicians Committee on Minority Health Affairs
11400 Tomahawk Creek Pkwy
Leawood, KS 66211-2672
913 906-6000
www.aafp.org

American Medical Association - Cultural Competence Compendium Web site
www.ama-assn.org/ama/pub/category/2661.html
e-mail: ccc@ama-assn.org

American Medical Association - Health Literacy Program Kit Ordering Information
515 N State St
Chicago, IL 60610
312 464-5355

American Medical Association - Minority Affairs Consortium Department of Women and Minority Services
515 N State St
Chicago, IL 60610
312 464-4392
www.ama-assn.org/mps

American Medical Student Association
1902 Association Dr
Reston, VA 20191
703 620-5873; fax 703 620-5873
e-mail: amsa@amsa.org
www.amsa.org

American Nurses Association
600 Maryland Ave SW, Suite 100 West
Washington, DC 20024
800 274-4262; fax 202 651-7001
www.nursingworld.org

American Psychiatric Association Office of Minority and National Affairs
1400 K St NW
Washington, DC 20005
888 357-7924; fax 202 682-6850
e-mail: apa@psych.org
www.psych.org

American Psychological Association Office of Ethnic Minority Affairs
750 First St NE
Washington, DC 20002
202 336-5500
www.apa.org

American Public Health Association
801 I St NW
Washington, DC 20001-3710
202 777-2742; fax 202 777-2534
www.apha.org

American Translators Association
225 Reinekers Ln, Suite 590
Alexandria, VA 22314
703 683-6100
www.atanet.org

Asian Community Mental Health Services
310 8th Street, Suite 201
Oakland, CA 94607
510 451-6729
www.acmhs.org

**Asian and Pacific Islander American
Health Forum**
942 Market St, Suite 200
San Francisco, CA 94102
415 954-9988; fax 415) 954-9999
www.apiahf.org

ASPIRA National Health Careers Program
1444 I St NW, Suite 800
Washington, DC 20005
202 835-3600; fax 202 835-3613
www.aspira.org

**Association for Multicultural Counseling
and Development**
5999 Stevenson Ave
Alexandria, VA 22304
800 347-6647
www.counseling.org

Association of American Indian Physicians
1225 Sovereign Row, Suite 103
Oklahoma City, OK 73108
405 946-7072; fax 405 946-7651
e-mail: aaip@aaip.com
www.aaip.com

Association of American Medical Colleges
2450 N St NW
Washington, DC 20037-1126
202 828-0400; fax 202 828-1125
www.aamc.org

**Association of Asian/Pacific Community
Health Organizations (AAPCHO)**
439 23rd St
Oakland, CA 94612
510 272-9536; fax 510 272-0817
www.aapcho.org

Association of Clinicians for the Underserved
501 Darby Creek Rd, Suite 20
Lexington, KY 40509-1606
859 263-0046; fax 859 263-7580
e-mail: acu@clinicians.org
www.clinicians.org

**Association of State and Territorial
Health Officials**
1275 K St NW, Suite 800
Washington, DC 20005-4006
202 371-9090; fax 202 371-9797
www.astho.org

Bureau of Primary Health Care
Health Resources Service Administration
4350 East-West Hwy
Bethesda, MD 20814
301 594-4100
800 400-2742 (Clearinghouse number)
www.bphc.hrsa.gov

Center of Substance Abuse Prevention
US Department of Health and
Human Services
Alcohol, Drug Abuse, and Mental
Health Administration
5600 Fishers Ln
Rockville, MD 20852
301 443-2403
www.samhsa.gov

Center for Race and Ethnicity in Medicine
University of Wisconsin School
of Medicine
1224 Medical Sciences Center
1300 University Ave
Madison, WI 53706-1532
608 265-5996; fax 608 262-2327
www.wisc.edu/crem

Chinese American Medical Society, Inc
281 Edgewood Ave
Teaneck, NJ 07666
201 833-1506

The Center for Cross Cultural Health
1313 SE 5th St, Suite 100B
Minneapolis, MN 55414
612 379-3573; fax 612 623-3002
e-mail: ccch@crosshealth.com
www.crosshealth.com

The Commonwealth Fund
1 E 75th St
New York, NY 10021-2692
212 606-3800; fax 212 606-3500
e-mail: cmwf@cmwf.org
www.cmwf.org

The Cross Cultural Health Care Program
Pacific Medical Clinics
1200 12th Ave S
Seattle, WA 98144
206 621-4161
www.xculture.org

CultureMed: SUNY Institute of Technology Library
PO Box 3051
Utica, NY 13504
www.sunyit.edu/library/culturemed

Indiana University Online Library
www.iun.indiana.edu/~lib/
*Contains information on transcultural
and multicultural health*

Henry J. Kaiser Family Foundation
2400 Sand Hill Rd
Menlo Park, CA 94025
650 854-9400; fax 650 854-4800
www.kff.org

Hispanic Serving Health Professions Schools, Inc
1411 K St NW, Suite 200
Washington, DC 20009
202 783-5262; fax 202 628-5898
e-mail: HISHPS@aol.com
www.HSHPS.com

Indian Health Service
5600 Fishers Ln #605
Rockville, MD 20852
301 443-1083
www.ihs.gov

Indians Into Medicine
University of North Dakota
School of Medicine
501 N Columbia Rd
Grand Forks, ND 58203
701 777-3037; fax 701 777-3277
www.med.und.nodak.edu/depts/inmed/home.htm

Intercultural Cancer Council
PMB-C, 1720 Dryden
Houston, TX 77030
713 798-4617; fax 713 798-3990
icc.bcm.tmc.edu

Interpreter Services Program
University of Massachusetts Memorial
Medical Center
55 Lake Ave N
Worcester, MA 01655
508 856-8989

Latino Coalition for a Healthy California
1535 Mission St
San Francisco, CA 94103
415 431-7430
www.lchc.org

Maternal and Child Health Bureau
5600 Fishers Ln
Rockville, MD 20852
301 443-2170
www.mchb.hrsa.gov

Minority Cultural Initiative Project
Research and Training Center on Family
Support and Children's Mental Health
Portland State University
PO Box 751
Portland, OR 97207-0751
503 725-4040; fax 503 725-4180
www.rtc.pdx.edu

The National Alliance for Hispanic Health
1501 16th St NW
Washington, DC 20036-1401
202 387-5000
www.hispanichealth.org

National Asian Women's Health Organization
250 Montgomery St, Suite 900
San Francisco, CA 94104
415 989-9747

**National Association for the Advancement
of Colored People (NAACP)**
4805 Mt Hope Dr
Baltimore, MD 21215
410 521-4939
www.naacp.org

National Association of Black Social Workers
8436 W McNichols
Detroit, MI 48221
313 862-6700; fax 313 862-6998
www.nabsw.org

National Association of Hispanic Nurses
1501 16th St NW
Washington, DC 20036
202 387-2477; fax 202 483-7183
www.thehispanicnurses.org

**National Association for Native American
Children of Alcoholics**
1402 Third Ave, Suite 1110
Seattle, WA 98101-2118
206 467-7686; fax 206 467-7689
www.ael.org/eric/ned/ned019.htm

National Black Child Development Institute, Inc
1101 15th St NW, Suite 900
Washington, DC 20005
202 833-2220; fax 202 833-8222
www.nbcdi.org

National Black Nurses' Association, Inc
8630 Fenton St, Suite 330
Silver Springs, MD 20910-3803
301 589-3200

National Center for Cultural Competence
Georgetown University Child
Development Center
3307 M St NW, Suite 401
Washington, DC 20007-3935
800 788-2066 or 202 687-5387;
fax 202 687-8899
[www.dml.georgetown.edu/depts/
pediatrics/gucdc](http://www.dml.georgetown.edu/depts/pediatrics/gucdc)

National Center for Youth with Disabilities
University of Minnesota
420 Delaware
Box 721
Minneapolis, MN 55455
612 626-4032; fax 612 626-2134;
TTY 612 624-3939
[www.peds.umn.edu/Centers/ihd/
ncyd.html](http://www.peds.umn.edu/Centers/ihd/ncyd.html)

National Council of LaRaza
1111 19th St NW, Suite 1000
Washington, DC 20036
202 785-1670
www.nclr.org

National Hispanic Medical Association
1411 K St NW, Suite 200
Washington, DC 20005
202 628-5895; fax 202 628-5898
e-mail: nhma@earthlink.net
www.home.earthlink.net/~nhma/

National Indian Health Board
1385 S Colorado Blvd, Suite A-707
Denver, CO 80222
303 759-3075
www.nihb.org

National Institutes of Health
Addressing Health Disparities:
The NIH Program of Action
Bethesda, MD 20892
www.healthdisparities.nih.gov

National Medical Association
1012 10th St NW
Washington DC, 20001
202 347-1895; fax 202 842-3293
www.natmed.org

National Minority AIDS Council
1931 13th St NW
Washington, DC 20009
202 483-6622; fax 202 483-1135
www.nmac.org

National Minority Health Association
2854 N Second St
Harrisburg, PA 17110
717 260-0409

National Urban League, Inc
120 Wall St
New York, NY 10005
212 558-5300
www.nul.org

New York University School of Medicine
Office of Minority Affairs and
Student Services
Schwartz Lecture Hall
550 First Ave
New York, NY 10016
www.med.nyu.edu/som/minority.html

Office of Civil Rights
US Department of Health and
Human Services
200 Independence Ave SW
Room 509F HHH Bldg
Washington, DC 20201
800 368-1019
www.hhs.gov/ocr

**Office of Disease Prevention and
Health Promotion**
National Health Information Center
PO Box 1133
Washington, DC 20013-1133
800 336-4797; 301 565-4167;
fax 301 984-4256
www.odphp.osophs.dhhs.gov

Office of Minority Health Resource Center
PO Box 37337
Washington, DC 20013-7337
800 444-MHRC (6472)
www.omhrc.gov

Pan American Health Organization
525 23rd St NW
Washington, DC 20037
202 974-3000; fax 202 974-3663
www.paho.org

Resources for Cross-Cultural Health Care
8915 Sudbury Rd
Silver Spring, MD 20901
301 588-6051
www.diversityRx.org

Student National Medical Association
5113 Georgia Ave NW
Washington, DC 20011
202 882-2881
www.snma.org

United National Indian Tribal Youth Inc
PO Box 800
Oklahoma City, OK 73101
405 236-2800
www.unityinc.org

University of Miami On-line Library
www.library.miami.edu
*Provides information on sociocultural
diversity and healthcare resources*

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Appendix

Youth Risk Behavior Surveillance Survey (YRBS)

Background on YRBS

The US Youth Risk Behavior Surveillance Survey (YRBS) monitors six categories of health risk behaviors among youth and young adults. These six categories of health-risk behaviors are behaviors that contribute to unintentional and intentional injuries; alcohol and other drug use; tobacco use; sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs) (including human immunodeficiency virus [HIV] infection); unhealthy dietary behaviors; and physical activity. The survey data collected includes surveys conducted by the Centers for Disease Control and Prevention (CDC), states, and territories, and local school-based surveys conducted by education and health agencies. The results summarized here on racial and ethnic disparities in youth risk behaviors are from the national survey, 33 state surveys, and 16 local surveys conducted among high school students during February through May of 1999.

Data below from: Youth Risk Behavior Surveillance - United States, 1999. MMWR Morb Mortal Wkly Rep. 2000;49(No.SS-5).

Behaviors that contribute to unintentional injuries

Seat belt use

- Nationwide, 16.4% of students had rarely or never worn seat belts when riding in a car or truck driven by someone else.
- Overall, male students (20.8%) were significantly more likely than female students (11.9%) to have rarely or never worn seat belts. This significant sex difference was identified for white and Hispanic students.

Motorcycle helmet use

- During the 12 months preceding the survey, 23.9% of students nationwide had ridden a motorcycle.
- Overall, Hispanic students (49.9%) were significantly more likely than white students (33.8%) to have rarely or never worn a motorcycle helmet.
- Hispanic female students (44.5%) were significantly more likely than white female students (20.1%) to report rarely or never having worn a motorcycle helmet.

Bicycle helmet use

- Nationwide, 70.8% of students had ridden a bicycle during the 12 months preceding the survey.
- Overall, African American students (91.9%) were significantly more likely than white students (84.3%) to have rarely or never worn a bicycle helmet.
- African American female students (94.1%) were significantly more likely than Hispanic (83.4%) or white (82.1%) female students to have rarely or never worn a bicycle helmet.

Injurious physical activity

- 37.7% of students nationwide had been treated by a doctor or nurse for injuries sustained while exercising, playing sports, or being physically active during the 12 months preceding the survey.
- Male students (42.5%) were significantly more likely than female students (32.7%) to have been injured while being physically active. This significant sex difference was identified for all racial/ethnic subpopulations.
- Overall, white students (38.7%) were significantly more likely than African American students (32.6%) to have been injured while being physically active.

Riding with a driver who had been drinking alcohol

- One-third (33.1%) of students nationwide had ridden one or more times with a driver who had been drinking alcohol during the 30 days preceding the survey.
- Overall, Hispanic students (39.5%) were significantly more likely than white students (32.4%) to have ridden with a driver who had been drinking alcohol.
- Hispanic male students (41.8%) were significantly more likely than white students (33%) to report riding with a driver who had been drinking alcohol.

Driving after drinking alcohol

- Nationwide, 13.1% of students had driven a vehicle one or more times after drinking alcohol during the 30 days preceding the survey.
- White students (14.6%) were significantly more likely than African American students (7.9%) to have driven after drinking alcohol.
- White female students (10.3%) were significantly more likely than African American female students (5.4%) to have driven after drinking alcohol.
- White (18.7%) and Hispanic (17.2%) male students were significantly more likely than African American (10.6%) male students to report driving after drinking alcohol.

Behaviors that contribute to intentional injuries

Carrying a weapon

Nationwide, 17.3% of students carried a weapon (eg, gun, knife, or club) on one or more of the 30 days preceding the survey.

Overall, male students (28.6%) were significantly more likely than female students (6.0%) to have carried a weapon. This significant sex difference was identified for all the racial and ethnic subpopulations.

African American (11.7%) and Hispanic (8.4%) female students were significantly more likely than white (3.6%) female students to have carried a weapon.

Physical fighting

- Nationwide, 35.7% of students had been in a physical fight one or more times during the 12 months preceding the survey.
- Overall, Hispanic students (39.9%) were significantly more likely than white students (33.1%) to have been in a physical fight.
- African American female students (38.6%) were significantly more likely than white female students (22.3%) to report physical fighting.
- African American (6.3%) and Hispanic (5.8%) students were significantly more likely than white students (3.2%) to have been injured in a physical fight.
- African American (6.6%) female students were significantly more likely than white (1.6%) female students to have been injured in a physical fight.

Dating violence

- Overall, African American students (12.4%) were significantly more likely than white students (7.4%) to report dating violence (eg, being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend).
- African American female students (14.1%) were significantly more likely than white female students (7.4%) to report dating violence.

Forced sexual intercourse

- Nationwide, 8.8% of students had ever been forced to have sexual intercourse when they did not want to.

Overall, African American (11.6%) and Hispanic (10.5%) students were significantly more likely than white (6.7%) students to have been forced to have sexual intercourse.

School-related violence

- 5.2% of students nationwide had missed one or more days of school during the 30 days preceding the survey because they had felt unsafe at school or when traveling to or from school.
- Overall, Hispanic (11.2%) students were significantly more likely than African American (6.0%) and white (3.9%) students to have missed school because they felt unsafe.
- Hispanic female (10.2%) students were significantly more likely than white female (4.3%) students to have missed school because they felt unsafe, and Hispanic males (12.3%) were significantly more likely than African American (4.9%) and white (3.6%) male students to have missed school because they felt unsafe.
- Nationwide, 6.9% of students reported weapon carrying on school property on one or more of the 30 days preceding the survey.
- Overall, male students (11.0%) were significantly more likely than female students (2.8%) to have carried a weapon on school property. This significant sex difference was identified for white and Hispanic students.
- Hispanic students (7.9%) were significantly more likely than African American students (5.0%) to have carried a weapon on school property.
- African American (4.8%) female students were significantly more likely than white (1.6%) female students to have carried a weapon on school property, and Hispanic (12.3%) and white (11.0%) male students were more likely than African American (5.3%) male students to have reported this behavior.
- Nationwide, the prevalence of students who had been threatened or injured with a weapon on school property one or more times during the 12 months preceding the survey was 7.7%.
- Overall, Hispanic (9.8%) students were significantly more likely than white (6.6%) students to have been threatened or injured with a weapon on school property.
- Hispanic (13.1%) male students were significantly more likely than white (7.9%) male students to report being threatened or injured with a weapon on school property.
- Nationwide, 14.2% of students had been in a physical fight on school property one or more times during the 12 months preceding the survey.
- Overall, African American (18.7%) students were significantly more likely than white (12.3%) students to have been in a physical fight on school property. African American (18.4%) female students were significantly more likely than white (7.1%) female students to have been in a physical fight on school property.

Sadness and suicide ideation and attempts

- Nationwide, during the 12 months preceding the survey, 28.3% of students felt so sad and hopeless almost every day for greater than or equal to 2 weeks in a row that they stopped doing some usual activities.
- Overall, female (35.7%) students were significantly more likely than male (21.0%) students to have felt sad or hopeless almost every day for greater than or equal to 2 weeks. This significant sex difference was identified for all racial/ethnic and grade subpopulations.
- Overall, Hispanic (37.0%) students were significantly more likely than African American (28.9%) and white (24.9%) students to have felt sad or hopeless almost every day for greater or equal to 2 weeks.
- Hispanic (46.1%) female students were significantly more likely than African American (37.7%) and white (31.3%) female students to have felt sad or hopeless almost every day for greater than or equal to 2 weeks.
- Hispanic (27.4%) male students were significantly more likely than white (19.0%) male students to have felt sad or hopeless almost everyday for greater than or equal to 2 weeks.
- Nationwide, 19.3% of students had seriously considered attempting suicide during the 12 months preceding the survey. Overall, female (24.9%) students were significantly more likely than male (13.7%) to have considered attempting suicide. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 9, 10, and 11.
- Overall, Hispanic (19.9%) students were significantly more likely than African American (15.3%) students to have considered attempting suicide. Hispanic (26.1%) female students were significantly more likely than African American (18.8%) female students to have considered attempting suicide.
- During the 12 months preceding the survey, more serious suicide ideation was reported by 14.5% of students nationwide, who had made a specific plan to attempt suicide.
- Overall, Hispanic (17.7%) students were significantly more likely than white (12.4%) and African American (11.7%) students to have made a suicide plan.
- Hispanic (23.3%) female students were significantly more likely than white (15.5%) and African American (13.7%) female students to have made a suicide plan.
- Nationwide, 8.3% of students had attempted suicide one or more times during the 12 months preceding the survey.

- Overall, Hispanic (12.8%) students were significantly more likely than African American (6.7%) and white (7.3%) students to have attempted suicide.
- Hispanic (18.9%) students were significantly more likely than white (9.0%) and African American (7.5%) students to have attempted suicide.
- Nationwide, 2.6% of students had made a suicide attempt during the 12 months preceding the survey that resulted in injury, poisoning, or overdose that had to be treated by a doctor or nurse.
- Hispanic (4.6%) female students were significantly more likely than Hispanic (1.4%) male students to have made a suicide attempt that required medical attention.

Tobacco use

Cigarette use

- Nationwide, 70.4% of students had ever tried cigarette smoking (even one or two puffs) (ie, lifetime cigarette use).
- Overall, white (29.3%) students were significantly more likely than Hispanic (19.6%) and African American (11.2%) students to report lifetime daily cigarette use.
- White (29.2%) female students were significantly more likely than Hispanic (18.2%) and African American (8.0%) female students to report lifetime daily cigarette use.
- One-third of students nationwide had smoked cigarettes on one or more of the 30 days preceding the survey (ie, current cigarette use).
- Overall, white (38.6%) and Hispanic (32.7%) students were significantly more likely than African American (19.7%) students to report current cigarette use. This significant racial/ethnic difference was identified among both female and male students.
- 16.8% of students nationwide had smoked cigarettes on 20 or more of the 30 days preceding the survey (ie, current frequent cigarette use).
- Overall, white (20.2%) students were significantly more likely than Hispanic (10.4%) and African American (7.0%) students to report current frequent cigarette use. This significant racial/ethnic difference was identified for both female and male students.
- 5.2% of students nationwide who reported current cigarette use smoked more than 10 cigarettes a day.
- White (6.6%) and Hispanic (2.7%) students were significantly more likely than African American (0.9%) students to smoke more than 10 cigarettes a day.

- White (4.9%) female students were significantly more likely than African American (1.0%) female students to smoke more than 10 cigarettes a day.
- White (8.4%) and Hispanic (3.5%) male students were significantly more likely than African American (0.8%) students to smoke more than 10 cigarettes a day.

Smokeless tobacco use

- 7.8% of students nationwide had used smokeless tobacco (chewing tobacco or snuff) on one or more of the 30 days preceding the survey (ie, current smokeless tobacco use).
- Overall, white (10.4%) students were significantly more likely than Hispanic (3.9%) and African American (1.3%) students to report current smokeless tobacco use.
- White (1.5%) female students were significantly more likely than African American (0.2%) female students to report current smokeless tobacco use.
- White (18.8%) male students were significantly more likely than Hispanic (6.1%) and African American (2.5%) male students to report current smokeless tobacco use.

Cigar use

- Nationwide, 17.7% of students had smoked cigars, cigarillos, or little cigars on one or more of the 30 days preceding the survey (ie, current cigar use).
- Overall, white (18.8%) students were significantly more likely than African American (13.7%) students to report current cigar use.
- White (28.3%) male students were significantly more likely than African American (16.0%) male students to report current cigar use.

Current tobacco use

- Nationwide, 32.8% of students had reported current cigarette use, current smokeless tobacco use, or current cigar use (ie, current tobacco use).
- Overall, male (37.6%) students were significantly more likely than female (27.9%) students to report current tobacco use. This significant sex difference was identified for white students and students in grades 10, 11, and 12.
- Overall, white (36.2%) and Hispanic (31.3%) students were significantly more likely than African American (20.9%) students to report current tobacco use. This significant racial/ethnic difference was identified for both female and male students.

Alcohol and other drug use

Alcohol use

- Nationwide, 81.0% of students had had one or more drinks of alcohol during their lifetime (ie, lifetime alcohol use).
- Overall, Hispanic (83.4%) students were significantly more likely than African American (74.8%) students to report lifetime alcohol use.
- White (81.8%) male students were significantly more likely than African American (73.8%) male students to report lifetime alcohol use.
- Half of all students (50.0%) nationwide had had one or more drinks of alcohol on one or more of the 30 days preceding the survey (ie, current alcohol use).
- Overall, Hispanic (52.8%) and white (52.5%) students were significantly more likely than African American (39.9%) students to report current alcohol use.
- Nationwide, 31.5% of students had had five or more drinks of alcohol on one or more occasions during the 30 days preceding the survey (ie, episodic heavy drinking).
- Overall, male (34.9%) students were significantly more likely than female (28.1%) students to report episodic heavy drinking. This significant sex difference was identified for white and Hispanic students and students in grade 12.
- White (35.8%) and Hispanic (32.1%) students were significantly more likely than African American (16.0%) students to report episodic heavy drinking. This significant racial/ethnic difference was identified for both female and male students.

Marijuana use

- Nationwide, 47.2% of students had used marijuana during their lifetime (ie, lifetime marijuana use).
- Overall, male (30.8%) students were significantly more likely than female (22.6%) students to report marijuana use. This significant sex difference was identified for Hispanic students.

Cocaine use

- Nationwide, 9.5% of students had used a form of cocaine (eg, powder, crack, freebase) during their lifetime (ie, lifetime cocaine use).
- Overall, Hispanic (15.3%) and white (9.9%) students were significantly more likely than African American (2.2%) students to report lifetime cocaine use.
- Hispanic (12.3%) and white (8.7%) female students were significantly more likely than African American (1.5%) female students to report lifetime cocaine use.

- Hispanic (18.3%) and white (11.0%) male students were significantly more likely than African American (2.8%) male students to report lifetime cocaine use.
- Nationwide, 4.0% of students had used a form of cocaine greater one or more times during the 30 days preceding the survey (ie, current cocaine use).
- Overall, Hispanic (6.7%) and white (4.1%) students were significantly more likely than African American (1.1%) students to report current cocaine use.
- Hispanic (5.4%) female students were significantly more likely than African American (1.1%) female students to report current cocaine use.
- Hispanic (8.0%) and white (5.3%) male students were significantly more likely than African American (1.0%) male students to report current cocaine use.

Inhalant use

- Nationwide, 14.6% of students had sniffed glue, breathed the contents of aerosol cans, or inhaled any paints or spray to get high during their lifetime (ie, lifetime inhalant use).
- Overall, white (16.4%) and Hispanic (16.1%) students were significantly more likely than African American (4.5%) students to report lifetime inhalant use. This significant racial/ethnic difference was identified for both female and male students.
- Nationwide, 4.2% of students had used inhalants one or more times during the 30 days preceding the survey (ie, current inhalant use).
- Overall, Hispanic (4.9%) and white (4.4%) students were significantly more likely than African American (2.3%) students to report current inhalant use. This significant racial/ethnic difference was identified for male students.

Heroin use

- Nationwide, 2.4% of students had used heroin during their lifetime (ie, lifetime heroin use).
- Nationwide, 9.1% of students had used methamphetamines during their lifetime (ie, lifetime methamphetamine use).
- Overall, Hispanic (11.3%) and white (10.3%) students were significantly more likely than African American (1.7%) students to report lifetime methamphetamine use. This significant racial/ethnic difference was identified for both female and male students.

Steroid use

- Nationwide, 3.7% of students had used illegal steroids (ie, without a doctor's prescription) during their lifetime (ie, lifetime steroid use).
- Overall, white (4.1%) students were significantly more likely than African American (2.2%) students to report lifetime steroid use.
- Hispanic (3.4%) female students were significantly more likely than African American (0.9%) female students to report lifetime steroid use.

Initiation of risk behaviors

Cigarette smoking

- Overall, white (26.2%) and Hispanic (25.1%) students were significantly more likely than African American (14.4%) students to have smoked a whole cigarette before age 13 years. This significant racial/ethnic difference was identified for both female and male students.

Alcohol use

- Nationwide, 32.2% of students had first drunk alcohol (more than a few sips) before the age of 13 years. Overall, male (37.4%) students were significantly more likely than female (26.8%) students to have drunk alcohol before the age of 13 years. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 11 and 12.

Marijuana use

- Nationwide, 11.3% of students had tried marijuana before age 13 years.
- Overall, Hispanic (13.9%) students were significantly more likely than white (9.4%) students to have tried marijuana before 13 years. This significant racial/ethnic difference was identified for male students.

Tobacco, alcohol, and other drug use on school property

- Nationwide, 14.0% of students had smoked cigarettes on school property on one or more of the 30 days preceding the survey.
- Overall, white (15.6%) and Hispanic (12.9%) students were significantly more likely than African American (6.7%) students to have smoked cigarettes on school property.
- Nationwide, 4.2% of students had used smokeless tobacco on school property on one or more of the 30 days preceding the survey.

- Overall, white (5.9%) and Hispanic (2.5%) students were significantly more likely than African American (0.5%) students to have used smokeless tobacco on school property.
- Nationwide, 4.9% of students had had one or more drinks of alcohol on school property on one or more of the 30 days preceding the survey.
- Hispanic female (6.7%) students were significantly more likely than white (3.4%) and African American (2.6%) female students to have drunk alcohol on school property.
- Nationwide, 7.2% of students had used marijuana on school property one or more times during the 30 days preceding the survey.
- Overall, Hispanic (10.7%) students were significantly more likely than white (6.5%) students to have used marijuana on school property. This significant racial/ethnic difference was identified for female students
- Nationwide, 30.2% of students had been offered, sold, or given an illegal drug on school property during the 12 months preceding the survey.
- Overall, Hispanic (36.9%) students were significantly more likely than white (28.8%) and African American (25.3%) students to have been offered, sold, or given an illegal drug on school property. This significant racial/ethnic difference was identified for male students.

Sexual behaviors that contribute to unintended pregnancy and STDs, including HIV infection

Sexual intercourse

- Half (49.9%) of all students had had sexual intercourse during their lifetime.
- Hispanic (62.9%) male students were significantly more likely than Hispanic (45.5%) female students to have had sexual intercourse.
- Overall, African American (71.2%) students were significantly more likely than Hispanic (54.1%) and white (45.1%) students to have had sexual intercourse. This significant racial/ethnic difference was identified for both female and male students.
- Nationwide, 8.3% of students had initiated sexual intercourse before age 13 years.
- Overall, African American (20.5%) students were significantly more likely than Hispanic (9.2%) and white (5.5%) students to have initiated sexual intercourse before age 13 years.
- Nationwide, 16.2% of all students had had sexual intercourse during their lifetime with four or more sex partners.

- Overall, African American students (34.4%) were significantly more likely than Hispanic (16.6%) and white (12.4%) students to have had four or more sex partners.
- Nationwide, 36.3% of all students had had sexual intercourse during the 3 months preceding the survey (ie, currently sexually active).
- Overall, African American (53.0%) students were significantly more likely than Hispanic (36.3%) and white (33.0%) students to be currently sexually active. This significant race/ethnic difference was identified for both male and female students.

Condom use

- Among currently active students nationwide, 58.0% reported that either they or their partner had used a condom during last sexual intercourse.
- Overall, male (65.5%) students were significantly more likely than female (50.7%) students to report condom use. This significant sex difference was identified for white and Hispanic students in grades 11 and 12.
- Overall, African American (70.0%) students were significantly more likely than Hispanic (55.2%) and white (55.0%) students to report condom use.
- Overall, African American (64.5%) female students were significantly more likely than white (47.6%) and Hispanic (43.0%) female students to report condom use.
- African American (75.3%) male students were significantly more likely than white (63.0%) male students to report condom use.

Birth control pill use

- Among currently sexually active students nationwide, 16.2% reported that either they or their partner had used birth control pills before last sexual intercourse.
- Overall, white (21.0%) students were significantly more likely than Hispanic (7.8%) and African American (7.7%) students to report birth control use. This significant racial/ethnic difference was identified for both female and male students.

Alcohol or drug use at last sexual intercourse

- Among currently sexually active students nationwide, 24.8% had used alcohol and drugs at last sexual intercourse.
- Overall, male (31.2%) students were significantly more likely than female (18.5%) students to have used alcohol or drugs at last sexual intercourse. This significant sex difference was identified for all racial/ethnic subpopulations and students in grade 11.

Pregnancy

- Nationwide, 6.3% of students reported that they had been pregnant or had gotten someone else pregnant.
- Overall, African American (13.4%) students were significantly more likely than white (4.3%) students to have been pregnant or to have gotten someone pregnant. This significant racial/ethnic difference was identified for both male and female students.

HIV education

- Nationwide, 90.6% of students had been taught in school about acquired immunodeficiency syndrome (AIDS) or HIV infection.
- Overall, white (92.2%) students were significantly more likely than Hispanic (84.1%) students to have received HIV education in school. This racial/ethnic difference was identified for both female and male students.

Dietary behaviors

Overweight

- Nationwide, 16.0% of students were at risk for becoming overweight (ie, having a BMI greater than or equal to 85th percentile and less than 95th percentile by age and sex).
- Overall, African American (22.0%) students were significantly more likely than white (14.4%) students to be at risk for becoming overweight.
- African American (22.6%) and Hispanic (18.3%) female students were significantly more likely than white (12.4%) female students to be at risk for becoming overweight.
- Nationwide, 30.0% of students thought they were overweight.
- Overall, female (36.4%) students were significantly more likely than male (23.7%) students to consider themselves overweight. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 10, 11, and 12.
- Overall, Hispanic (36.7%) students were significantly more likely than white (29.2%) and African American (24.9%) students to consider themselves overweight.
- Nationwide, 42.7% of students were trying to lose weight during the 30 days preceding the survey.
- Overall, female (59.4%) students were significantly more likely than male (26.1%) students to be trying to lose weight. This significant sex difference was identified for all racial/ethnic and grade subpopulations.

- Overall, Hispanic (50.6%) and white (42.6%) students were significantly more likely than African American (36.3%) students to be trying to lose weight.

Consumption of fruits and vegetables

- Nationwide, 23.9% of students had eaten five or more servings per day of fruits and vegetables during the 7 days preceding the survey.

Consumption of milk

- Nationwide, 18.0% of students drank three or more glasses of milk per day during the 7 days preceding the survey.
- Overall, male (23.0%) students were significantly more likely than female (12.9%) students to have drunk three or more glasses of milk per day. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 9, 10, and 12.
- Overall, white (19.6%) and Hispanic (15.8%) students were significantly more likely than black (10.8%) students to have drunk three or more glasses of milk per day.

Attempted weight control

- Nationwide, 58.4% of students had exercised to lose weight or to avoid gaining weight during the 30 days preceding the survey.
- Overall, female (67.4%) students were significantly more likely than male (49.5%) students to have exercised to lose weight or to avoid gaining weight. This significant sex difference was identified for white and Hispanic students in all grade subpopulations.
- Nationwide, 40.4% of students had eaten less food, fewer calories, or foods low in fat to lose weight or to avoid gaining weight during the 30 days preceding the survey.
- Overall, female students (56.1%) were significantly more likely than male students (25.0%) to have eaten less food, fewer calories, or foods low in fat to lose weight or to avoid gaining weight. This significant sex difference was identified for all the racial/ethnic and grade subpopulations.
- Overall, white (42.1%) students were significantly more likely than African American (34.5%) students to have eaten less food, few calories, or foods low in fat to lose weight or to avoid gaining weight.
- Nationwide, 12.6% of students had gone without eating for greater than or equal to 24 hours to lose weight or to avoid gaining weight.

- Overall, female (18.8%) students were significantly more likely than male (6.4%) students to have gone without eating for 24 hours or more to lose weight or to avoid gaining weight. This significant sex difference was identified for all racial/ethnic and grade subpopulations.
- Nationwide, 7.6% of students had taken diet pills, powders, or liquids without a doctor's advice to lose weight or to avoid gaining weight.
- White female (11.7%) students were significantly more likely than African American (6.9%) students to report having taken diet pills, powders, or liquid without a doctor's advice to lose weight or to avoid gaining weight.
- Nationwide, 4.8% of students had vomited or taken laxatives to lose weight or to avoid gaining weight.
- Overall, female (7.5%) students were significantly more likely than male (2.2%) students to have vomited or taken laxatives to lose weight or to avoid gaining weight. This significant sex difference was identified for white students and students in all grade subpopulations.
- Hispanic (4.0%) and African American (3.4%) male students were significantly more likely than white (1.5%) male students to have vomited or taken laxatives to lose weight or to avoid gaining weight.

Physical activity

Vigorous and moderate physical activity

- Approximately 64.7% of students nationwide had participated in activities that made them sweat and breathe hard for 20 minutes or more on three or more of the 7 days preceding the survey (ie, vigorous physical activity).
- Overall, male (72.3%) students were significantly more likely than female (57.1%) students to report vigorous activity. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 10, 11, and 12.
- Overall, white (67.4%) students were significantly more likely than African American (55.6%) students to report vigorous physical activity.
- White (59.7%) female students were significantly more likely than Hispanic (49.5%) and African American (47.2%) female students to report vigorous physical activity.
- 26.7% of students nationwide had participated in activities that did not make them sweat or breathe hard for 30 minutes or more on five or more of the 7 days preceding the survey (ie, moderate physical activity).

- Overall, male (29.0%) students were significantly more likely than female (24.4%) students to report moderate physical activity. This significant sex difference was identified for Hispanic students.
- Overall, white (28.8%) students were significantly more likely than Hispanic (21.4%) and black (20.9%) students to report moderate physical activity. This significant racial/ethnic difference was identified for female students.

Strengthening exercises

- Nationwide, 53.6% of students had done strengthening exercises (eg, push-ups, sit-ups, and weightlifting) on three or more of the 7 days preceding the survey.
- Overall, male (63.5%) students were significantly more likely than female (43.6%) students to have participated in strengthening exercises. This significant sex difference was identified for all the racial/ethnic and grade subpopulations.
- Overall, white (55.7%) students were significantly more likely than African American (45.1%) students to have participated in strengthening exercises. This significant racial/ethnic difference was identified for female students.

Watching television

- Nationwide, 57.2% of students watched television for 2 hours or less per day during an average school day.
- Overall, white (65.8%) students were significantly more likely than Hispanic (47.8%) or African American (26.3%) students to have watched television for 2 hours or less per day. This significant racial/ethnic difference was identified for both female and male students.

Participation in physical education class

- Nationwide, 56.1% of students were enrolled in a physical education class.
- Nationwide, 29.1% of students attended physical education class daily.
- Overall, white (78.7%) students were significantly more likely than African American (67.8%) students to have exercised longer than 20 minutes during an average physical education class.
- White (72.4%) and Hispanic (70.8%) students were significantly more likely than African American (55.7%) students to report exercising longer than 20 minutes during an average physical education class.
- Nationwide, 55.1% of students had played on sports teams during the 12 months preceding the survey.

- Overall, male (61.7%) students were significantly more likely than female (48.5%) students to have played on sports teams. This significant sex difference was identified for all the racial/ethnic subpopulations and students in grades 9, 11, and 12.
- Overall, white (56.9%) students were significantly more likely than Hispanic (50.8%) students to have played on sports teams.
- White (50.5%) students were significantly more likely than black (36.3%) female students to have played on sports teams.

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