

Cultural Competence and Tobacco Dependence

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Disclosure

I have no real or perceived vested interests that relate to this presentation nor do I have any relationships with pharmaceutical companies, biomedical device manufacturers, and/or other corporations whose products or services are related to pertinent therapeutic

Objectives

- To develop a definition Cultural Competence
- To examine the role cultural background has in smoking and smoking cessation
- To introduce and practice methods of providing care that addresses how culture may effect smoking behavior

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Important Theorists

“Named must be your fear before
banish it you can.”

Yoda



Definition of Cultural Competence?

The ability to understand and use information about an individual's cultural background to enhance the quality of your interaction with that person

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Definition of Cultural Competence?



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Definition of Cultural Competence?



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Cultural Competency: It's a trip, not a destination

- There's no such thing as Cultural Competence
- Individuals are at different stages of development on this topic. There is always room for growth as long as there is a willingness to do the learning
- Increase ability, desire and willingness to consider the role culture plays in smoking with your patients

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Stereotypes Vs. Generalizations

- The Problem :
 - If you don't consider generalizations about culture you may miss important information that could help inform your diagnosis/treatment
 - If you rely solely on generalizations (stereotypes) you risk providing inadequate treatment based on cultural prejudice

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Stereotypes Vs. Generalizations

- Some studies have shown that authoritarian parental messages may protect African-American youth against risky smoking behavior
- White girls are more likely than African American girls to think that smoking enhanced their self image

(Nichter, 2003)

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Differences in Tobacco Use

Tobacco Use Among U.S. Racial/Ethnic Minority Groups, African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, Hispanics: A Report of the Surgeon General (Executive Summary) (1998)

- Smoking is a major cause of disease and death in Minority Groups
- African Americans bear the greatest health burden
- American Indians and Alaska Natives have the highest prevalence of tobacco use
- African American and Southeast Asian men also have a high prevalence of smoking

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Differences in Tobacco Use

Tobacco Use Among U.S. Racial/Ethnic Minority Groups, African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, Hispanics: A Report of the Surgeon General (Executive Summary) (1998)

- African American and Hispanic Adolescents: cigarette smoking prevalence increased in the 1990s after several years of substantial decline
- No single factor determines patterns of tobacco use among racial/ethnic minority groups
- Prevention research are needed on the changing cultural, psychosocial, and environmental factors that influence tobacco use to improve our understanding of racial/ethnic smoking patterns & identify strategic tobacco control opportunities.

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Differences in Tobacco Use

TABLE 1. Percentage of persons aged 12–17 years reporting cigarette use during the preceding month, by race/ethnicity and sex — National Survey on Drug Use and Health, United States, 1999–2001

Race/Ethnicity	Male		Female		Total	
	%	(95% CI) [†]	%	(95% CI)	%	(95% CI)
Non-Hispanic						
White	14.9	(14.3–15.5)	17.2	(16.6–17.8)	16.0	(15.6–16.5)
Black	8.2	(7.2–9.2)	5.9	(5.1–6.8)	7.0	(6.4–7.7)
American Indian/Alaska Native	29.5	(22.8–37.3)	26.3	(20.8–32.6)	27.9	(23.7–32.5)
Hawaiian/Other Pacific Islander	7.0	(3.4–13.9)	— [‡]	—	11.0	(6.4–18.2)
Asian [§]	8.8	(6.7–11.6)	7.3	(5.6–9.5)	8.1	(6.6–9.9)
Chinese	6.3	(3.0–12.6)	5.4	(2.3–12.2)	5.9	(3.3–9.9)
Filipino	5.8	(3.0–11.1)	8.9	(4.9–15.7)	7.4	(4.8–11.2)
Japanese	—	—	—	—	5.2	(2.3–11.2)
Asian Indian	10.1	(4.9–19.8)	6.8	(2.9–15.1)	8.7	(5.0–14.7)
Korean	13.8	(7.9–23.0)	7.3	(3.5–14.5)	10.6	(6.8–16.4)
Vietnamese	—	—	8.0	(3.7–16.2)	6.8	(3.3–13.5)
Hispanic [§]	11.4	(10.3–12.7)	10.2	(9.1–11.4)	10.8	(10.0–11.7)
Mexican	11.4	(10.0–13.1)	10.6	(9.3–12.1)	11.0	(10.0–12.1)
Puerto Rican	11.2	(8.2–15.0)	10.4	(7.7–13.8)	10.8	(8.7–13.3)
Central or South American	9.9	(6.7–14.3)	9.3	(6.6–12.9)	9.6	(7.4–12.3)
Cuban	14.3	(7.9–24.5)	10.0	(6.0–16.0)	12.4	(8.0–18.7)
Total	13.3	(12.8–13.7)	14.2	(13.8–14.7)	13.8	(13.4–14.1)

[†] Confidence interval.

[‡] Data unreliable.

[§] Includes respondents reporting racial/ethnic subgroups not shown and respondents reporting more than one subgroup.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5303a2.htm#tab1>

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Differences in Tobacco Use

TABLE 2. Percentage of persons aged ≥18 years reporting cigarette use during the preceding month, by race/ethnicity and sex — National Survey on Drug Use and Health, United States, 1999–2001

Race/Ethnicity	Male		Female		Total	
	%	(95% CI) [†]	%	(95% CI)	%	(95% CI)
Non-Hispanic						
White	29.1	(28.4–29.8)	25.9	(25.2–26.6)	27.4	(26.9–27.9)
Black	30.1	(28.2–32.1)	22.2	(20.6–23.8)	25.7	(24.4–27.0)
American Indian/Alaska Native	40.9	(33.6–48.6)	40.0	(32.5–47.9)	40.4	(35.2–45.8)
Hawaiian/Other Pacific Islander	— [‡]	—	—	—	—	—
Asian [§]	24.1	(20.2–28.4)	9.1	(7.2–11.6)	16.2	(14.1–18.6)
Chinese	19.3	(13.7–26.4)	5.9	(3.0–11.2)	12.3	(8.9–16.8)
Filipino	—	—	6.9	(3.7–12.4)	14.8	(9.6–22.0)
Japanese	18.3	(12.9–25.3)	—	—	19.0	(13.4–26.2)
Asian Indian	20.0	(12.8–29.8)	3.0	(1.7–5.2)	12.6	(8.3–18.5)
Korean	—	—	—	—	27.2	(19.3–36.9)
Vietnamese	—	—	—	—	26.5	(18.2–36.9)
Hispanic [§]	29.2	(27.3–31.1)	17.3	(15.9–18.7)	23.1	(21.9–24.3)
Mexican	29.8	(27.6–32.2)	15.6	(13.9–17.5)	22.8	(21.4–24.4)
Puerto Rican	34.2	(28.2–40.8)	27.3	(22.2–33.0)	30.4	(26.5–34.7)
Central or South American	26.3	(21.8–31.3)	16.9	(13.2–21.3)	21.3	(18.5–24.5)
Cuban	21.1	(15.0–28.8)	17.5	(13.1–23.1)	19.2	(16.0–22.8)
Total	29.2	(28.6–29.8)	24.1	(23.6–24.7)	26.5	(26.1–27.0)

[†] Confidence interval.

[‡] Data unreliable.

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<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5303a2.htm#tab1>

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Health Disparities

- Institute of Medicine (IOM) report (2002). Minorities are less likely than Whites to receive needed services, including clinically necessary procedures.

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Health Disparities

"The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization"

Kevin A Schulman MD, et.al.

New England Journal of Medicine 1999;340:618-26

- Actors portrayed patients in scripted interviews about their symptoms. 720 physicians reviewed recorded videotapes of these interviews.
- Women were only 60% as likely to be referred for cardiac catheterization as men; Blacks were only 60% as likely to be referred for cardiac catheterization as whites. Black women were 40% as likely to be referred as white men.

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So How do we change our
behavior to be more attentive
to cultural issues in our
patients?

What do we *do* differently?

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Multicultural Interviewing

- Introduce multicultural interviewing

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Kleinman Questions: Background

- Difference between disease and illness
- Disease “abnormalities in structure/function of organs or systems”
- Illness “experiences of disvalued changes in states of being and social function; the human experience of sickness”

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Kleinman Questions: Background

- Illness is shaped by cultural, social and psychological factors
- For patients illness may be the entire problem
- Medicine can view disease as whole problem

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Kleinman Questions: Why do we need them?

- Diverging explanatory models/ Clinical realities cause problems in care
- Important to understand MD and patient's models and how they conflict
- Pt. feels understood and MD gains critical information

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Kleinman Questions: Why do we need them?

- Developing this understanding leads to increased rapport, better alliance between MD and Pt.
- Puts MD in a position where they can negotiate through conflicts in explanatory models
- Pts are more likely to follow MD's tx plan.

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- “It is more important to know what kind of patient has the disease than what kind of disease the patient has.”

– Sir William Osler

GREAT! BUT HOW DO WE ASK?

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Kleinman Questions:

- **What do you think has caused your problem?**
- **Why do you think it started when it did?**
- **What do you think your sickness does to you?
How does it work?**
- **How severe is your sickness? Will it have a short or a long course?**

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Kleinman Questions:

- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

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A Framework for Culturally Competent Clinical Practice E.T.H.N.I.C.

- **EXPLANATION:**
 - What do you think may be the reason you have these symptoms?
 - What do friends, family, others say about these symptoms?
 - Do you know anyone else who has had or who has this kind of problem?
 - Have you heard about it on TV or radio or read about it in a newspaper? (If patients cannot offer explanations, ask what most concerns them about their problems).

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TREATMENT:

- What kinds of medicines, home remedies, or other treatments have you tried for this illness?
- Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy?
- Please tell me about it. What kind of treatment are you seeking from me?

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HEALERS:

- Have you sought any advice from alternative/folk healers, friends, or other people (non-doctors) for help with your problems?
- Tell me about it.

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INTERVENTION:

- Determine an intervention with your patient.
- May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices

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COLLABORATION

- Collaborate with the patient, family members, other health care team members, healers, and community resources.

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Enhancing Your Cultural Communication Skills

- *So that I might be aware of and respect your cultural beliefs*
- Can you tell me what languages are spoken in your home and the languages that you speak?
- Can you tell me about beliefs and practices including special events that you feel I should know?

* Adapted from : University of Michigan's Program for Multicultural Health <http://www.med.umich.edu/multicultural/ccp/tools.htm#culcom>

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Enhancing Your Cultural Communication Skills

- How often each year did you see a health care provider before you arrived in the U.S.? Have you noticed any differences between the type of care you received in your native country and the type you receive here?
- Do you use any traditional health remedies?
- Are there certain health care procedures and tests which your culture prohibits?

* Adapted from : University of Michigan's Program for Multicultural Health <http://www.med.umich.edu/multicultural/ccp/tools.htm#culcom>

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The 5 R Model

- Relevance
- Risk
- Rewards
- Roadblocks
- Repetition

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The 5 R Model

- Relevance
 - Find out about cultural norms regarding smoking
 - What do your friends, family, religious leaders and/or coworkers think about smoking?
 - What do people think about smoking where you are from (in your neighborhood)?

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The 5 R Model

- Risks

- Find out which risks are culturally relevant

- What do you think of the health risks we discussed?
- How important are these in your family/country/friends/community in which you live?

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The 5 R Model

- Rewards

- Understand what positive benefits of quitting are most valuable to the client.

- Who would be most happy about you quitting and why?

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The 5 R Model

- Roadblocks

- Identify with the client the most significant barriers to their successful quitting.

- What are the things that make it difficult for you to quit?
 - What are some important values you have about smoking or not smoking?
 - Who would be upset if you quit and why?

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The 5 R Model

- Repetition

- Revisit any of the previous steps when there is difficulty due to cultural difference. Also an opportunity to affirm client and normalize these difficulties.

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Multicultural Interviewing: Guidelines and Issues

- **Tool to understand how culture interacts with tobacco use**
- **Useful with everyone**
- **With continuity/culturally different patients**
- **Have one or two regular questions**
- **What's difficult about Multicultural Interviewing?**

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Racism, Prejudice and Privilege

- **Raise awareness around issues of prejudice and privilege**
- **Begin to consider how these factors may play a role in the care we provide to patients**

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Privilege

- Members of majority groups have certain societal benefits that members of minority groups do not have
- More subtle than racism or prejudice
- Can be invisible
- Taken for granted
- May operate outside of awareness

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Privilege

- Skin color is one of the privilege variables that operates most often
- Other variables that confer/deprive privilege:
 - Gender
 - Age
 - Sexual Orientation
 - Economic Status
 - Disability Status
 - Religion
 - Immigration status

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Charged Situations

Skills

- Watch your defensiveness
- Ask Questions about pts. experience
- Relay empathy – Validate pt's situation

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Now what do I do?

- Understanding privilege is a good start
- Developing this awareness works to dissolve barriers to care and bridges gaps between culturally different people

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Now what do I do?

- Continue to be respectful and curious about the impact of culture on your relationships with patients and on their tobacco use
- Use multicultural interviewing to elicit culturally related health beliefs about smoking
- Try to negotiate these beliefs so that patients can consider cessation while honoring the cultural norms.

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Questions

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