

Commentary

Moving towards cultural competence in the treatment of pediatric chronic pain

Madison Perry, Jeffrey D. Shahidullah, and Mary K. Lynch

Introduction

Due to the multiple etiological pathways of chronic pain that implicate biological, psychological and sociocultural factors, interdisciplinary team-based treatment is recommended (Kerns et al., 2011). Cognitive behavioral therapy (CBT) is an evidence-based component of a comprehensive approach to the treatment of chronic pain (Ehde et al., 2014). In light of the historical misunderstanding and mistreatment of chronic pain based on cultural differences, cross-cultural adaptations of cognitive behavioral approaches to pain management are necessary to enhance the efficacy of treatment programs for diverse patient populations. This paper highlights acceptable practices in the treatment of pediatric chronic pain for pediatric psychologists working with diverse populations as well as future directions for research.

Cultural considerations in treatment

For racial and ethnic minority patients, there are numerous barriers to accessing behavioral health care, as well as disparities in the quality of behavioral health services provided to minorities (Miranda et al., 2008). Several researchers have examined cross-cultural perceptions of pain and differences in pain tolerance. Caldwell (2001) found that although rates of fibromyalgia do not differ across cultural groups, the condition is often misdiagnosed or underdiagnosed in Latinx and African American patients. Callister (2003) writes that the cultural and personal beliefs of patients make the assessment and treatment of chronic pain

difficult, thus perpetuating disparities in treatment outcomes for ethnic minority groups. For example, Palermo and colleagues (2012) posit that outpatient group-based CBT for specific types of chronic pain has shown to be effective and efficient. However, healthy cultural suspicion and mental health stigma in the African American community may lead African American children to be hesitant to openly discuss chronic pain in a group-based treatment (Boyd-Franklin, 2003). There is a clear and compelling need for future rigorous research, including randomized control trials, that include a wide range of ethnically and racially diverse treatment groups.

In addition to ethnicity, other aspects of culture include spiritual beliefs and orientation either toward the self (individualist) or the community (collectivist). These aspects of culture should also be considered as we adapt CBT frameworks to work with culturally diverse pediatric patients experiencing chronic pain. Bernal and colleagues (2009) review the frameworks for cultural adaptations to existing treatment models. They describe the ecological validity model (Bernal, 1995), the cultural adaptation process model (Domenech Rodríguez & Wieling, 2005), and Hwang's (2006) psychotherapy adaptation and modification framework. Various models have been adapted for parent management training with Mexican American families (Bernal et al., 2009), parent-child interaction training with Puerto Rican adolescents and their parents (Matos et al., 2006), and for CBT with Asian American children (Hwang,

2009). The evidence supports the argument that culturally-adapted therapies reduce treatment outcome disparities.

As societies become increasingly diverse, training in the delivery of tailored behavioral health services for ethnic minority groups is crucial (Sue, 1998). There are ethical grounds for developing and using culturally sensitive treatments. Cultural diversity is an area of human behavior like any other, requiring specialized knowledge and skills (Whaley & Davis, 2007). The American Psychological Association multicultural guidelines (APA, 2017) reflect advancements in the field of professional psychology and a leaning toward this ethical necessity of enhanced cultural competence. Cultural competence is not a trait nor a single event but rather a process in training and practice that is essential to providing culturally-responsive services (Campinha-Bacote, 2002).

Ahmann (2002) explains several reasons why culturally competent care is necessary, including:

1. Perceptions and causes of illness vary by culture
2. Culture influences help-seeking behavior and attitudes
3. Health care providers from culturally and linguistically diverse groups are underrepresented in the current service delivery system

Flores and colleagues (2000) describe the life-threatening and costly effects of culturally incompetent pediatric care in case reports of Latinx families seeking services in pediatric emergency departments. The Flores et al. (2000) case reports emphasize the negative impact that one-size-fits-all care has on culturally and linguistically diverse children and families by highlighting how providers may offer lower quality care to minority patients. Also noteworthy, in a survey of parents and families, 31% of Latina mothers reported that their providers' attitudes created a significant barrier to managing their children's conditions (Flores & Vega, 1998).

Building on research in providing culturally competent care to minorities, Diaz-Martinez and colleagues (2010) describe the integration of CBT, multicultural therapy, and feminist therapies with

Latinas. Diaz-Martinez, et al. (2010) highlight the importance of identifying environmental stressors and the impact that context and culturally-specific stressors can have on a patient's sense of self. Psychological treatments of choice for chronic pain typically fall under the umbrella of CBT, which can be amenable to adaptation and tailoring to a diverse range of patients by integrating culturally aware techniques and multicultural therapy frameworks.

Cultural awareness in the treatment of pediatric chronic pain

Researchers in multicultural psychology caution adoption of a one-size-fits-all approach to treatment (Bernal et al., 2008). In order to address some of the shortcomings of evidence-based treatment models, Pamela Hays (2009) wrote guidelines for culturally competent practices in the integration of multicultural therapy and CBT. Multicultural therapy is defined as any therapeutic intervention with ethnically diverse patient populations. Hays' guidelines for integrating culturally aware clinical judgment with evidence-based practices highlight the intersections of evidence-based practice, multicultural therapy, and advancing CBT research. Hays (2009) asserts that CBT and multicultural therapy have key factors in common including the focus on patients' strengths and empowerment. CBT through patient education and skills training, multicultural therapy through a therapeutic style that views cultural identity as a source of strength. She cautions that the theory that drives CBT must be re-conceptualized in order for CBT and multicultural therapy to align across a wide-range of cultural contexts. CBT asserts values from the dominant culture (i.e. assertiveness as an asset, independence over interdependence). Hays (2009) emphasizes the use of a patient's own cultural strengths in CBT interventions. Hays (2009) outlines culturally responsive multicultural therapy with specific suggestions for clinical practice:

1. Assess the patient's needs with an emphasis on culturally respectful behavior
2. Identify culturally-related strengths
3. Clarify what part of a patient's problem is environmental or cognitive with attention to cultural influences

4. Validate patients' self-reported experiences of oppression
5. Question the helpfulness (rather than the validity) of a thought in cognitive restructuring
6. Do not challenge core cultural beliefs

The treatment of pediatric chronic pain is often referred to as behavioral pain management (Johansson et al., 1998). At an integrated care clinic, patients and their families are often more amenable to this description as opposed to a psychotherapy label, potentially due to the complex nature of pain. The typical course of treatment in most forms of behavioral pain management is to first conduct a thorough assessment of symptoms and impairment; then to provide psychoeducation about pain, to teach skills (e.g. distraction, relaxation, behavioral activation, pacing), and to provide cognitive treatment that relates directly to a patient's functional impairments and treatment goals (Lynch-Jordan et al., 2014). The third item on Hays' (2009) list is particularly important during the assessment phase of pediatric behavioral pain management. The assessment or intake phase, by nature, is filled with questions about a patient's symptoms, their experience and their developmental history. This amount of questioning can be perceived as intrusive by many ethnic minority patients and families (Boyd-Franklin, 2003). During this phase it is also crucial to build rapport in order to prevent dropout and to obtain accurate information from patients. It is crucial to clarify which parts of a patient's experience are environmental. Case example: A patient identifying as biracial in a pediatric integrated care clinic identified that their peers ostracized them for missing school due to their chronic pain. Upon further assessment by the psychologist, it became clear that the patient had also historically experienced racism in their predominantly white school due to their racial identity.

Madison Perry, PsyM
 Graduate School of Applied and Professional Psychology, Rutgers, The State University of New Jersey, Piscataway, NJ, USA
 email: madison.perry@rutgers.edu

Culturally dependent attitudes towards therapy necessitate that clinicians tailor their treatment delivery based on the needs of each patient. Acceptance and Commitment Therapy (ACT) is a treatment approach with potential for cultural adaptation using Hays' suggestions. For instance, number six on her list (Hays, 2009) is a suggestion that can be seamlessly incorporated within the ACT framework. In traditional models of CBT, a pediatric psychologist might work with a patient who has chronic pain to challenge a maladaptive thought by questioning the validity of the thought (i.e. "Is it true?"). Conversely, within an ACT approach, the psychologist might explore the utility of the thought with the patient in the context of their values. The ACT approach lends itself to an individually tailored approach that may be appropriate for patients from varying ethnic backgrounds. For example, a pediatric patient with a strong evangelical Christian belief system benefited from an ACT approach to determine the role her endometriosis diagnosis and pain-specific thoughts played in her ability to engage in values-based activities. With this approach, patients' treatment goals (i.e. living a values-driven life) can be identified within their particular cultural framework.

Conclusion

There are clear disparities in quality of care delivery for pediatric chronic pain in ethnic-minority populations. The need remains for culturally-responsive adaptations of empirically-supported interventions when providing patient-centered care with this population (Hays, 2009). More research is needed in order to understand the effectiveness of using culturally-tailored strategies in treatment (Huey Jr., et al., 2014). Such research would further propel clinical practice and health care organizational system policy changes around the promotion of effective treatment of pediatric chronic pain in diverse populations.

Jeffrey D. Shahidullah, PhD
 Dell Medical School, The University of Texas at Austin, Austin, TX, USA

Mary K. Lynch, MA
 Division of Behavioral Medicine and Clinical
 Psychology, Cincinnati Children's, Cincinnati, OH,
 USA

References

- Abbasi S. Creating and delivering pain education for clinicians in a developing country. *Pediatric Pain Letter* 2018;20:1-4. www.childpain.org/ppl/issues/v20n1_2018/v20n1_abbasi.shtml
- Ahmann E. Developing cultural competence in healthcare settings: National Center for Cultural Competence. *Pediatr Nurs* 2002;28:133-137.
- American Psychological Association. Multicultural guidelines: an ecological approach to context, identity, and intersectionality, 2017. www.apa.org/about/policy/multicultural-guidelines.pdf
- Bernal G, Bonilla J, Bellido C. Ecological validity and cultural sensitivity for outcome research: issues for cultural adaptation and development of psychosocial treatments with Hispanics. *J Abnorm Child Psychol* 1995;23:67-82. www.pubmed.gov/7759675
- Bernal G, Jiménez-Chafey MI. Cultural adaptation of psychotherapy for ethnic-minority youth: Beyond one-size-fits-all. *Child Fam Policy Pract Rev* 2008;4:3-6.
- Bernal G, Jiménez-Chafey MI, Domenech Rodríguez, MM. Cultural adaptation of treatments: a resource for considering culture in evidence-based practice. *Prof Psychol Res Pr* 2009;40:361-368.
- Boyd-Franklin N. *Black families in therapy: understanding the African American experience*. New York: Guilford, 2003. www.worldcat.org/oclc/911684713
- Caldwell NL. The assessment of the influence of ethnicity, acculturation, and explanatory models on pain perception and the resulting impact on primary care patients with fibromyalgia. The University of Texas Southwestern Medical Center at Dallas, unpublished PhD Thesis, 2001.
- Callister LC. Cultural influences on pain perceptions and behaviors. *Home Health Care Manag Pract* 2003;15:207-211.
- Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: a model of care. *J Transcult Nurs* 2002;13:181-184. www.pubmed.gov/12113146
- Diaz-Martinez AM, Interian A, Waters DM. The integration of CBT, multicultural and feminist psychotherapies with Latinas. *J Psychother Integrat* 2010;20:312-326.
- Domenech-Rodríguez, M, Wieling E. Developing culturally appropriate, evidence-based treatments for interventions with ethnic minority populations. In: Rastogi M, Wieling E, editors. *Voices of color: first person accounts of ethnic minority therapists*. Thousand Oaks, CA: Sage, 2005. pp. 313-333. www.worldcat.org/oclc/217693346
- Ehde DM, Dillworth TM, Turner JA. Cognitive-behavioral therapy for individuals with chronic pain: efficacy, innovations, and directions for research. *Am Psychol* 2014;69:153-166. www.pubmed.gov/24547801
- Flores G, Vega LR. Barriers to health care access for Latino children: a review. *Fam Med* 1998;30:196-205.
- Flores G, Abreu M, Schwartz I, Hill M. The importance of language and culture in pediatric care: case studies from the Latino community. *Journal Pediatr* 2000;137:842-848. www.pubmed.gov/11113842
- Hays PA. Integrating evidence-based practice, cognitive-behavior therapy, and multicultural therapy: ten steps for culturally competent practice. *Prof Psychol Res Pr* 2009;40:354-360.
- Huey SJ Jr, Tilley JL, Jones EO, Smith CA. The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annu Rev Clin Psychol* 2014;10:305-338. www.pubmed.gov/24437436
- Hwang WC. The psychotherapy adaptation and modification framework: application to Asian Americans. *Am Psychol* 2006;61:702-715. www.pubmed.gov/17032070
- Hwang WC. The formative method for adapting psychotherapy (FMAP): a community-based developmental approach to culturally adapting therapy. *Prof Psychol Res Pr* 2009;40:369-377. www.pubmed.gov/20625458

Johansson C, Dahl J, Jannert M, Melin L, Andersson G. Effects of a cognitive-behavioral pain-management program. *Behav Res Ther* 1998;36:915-930. www.pubmed.gov/9714943

Kerns RD, Sellinger J, Goodin BR. Psychological treatment of chronic pain. *Annu Rev Clin Psychol* 2011;7:411-434. www.pubmed.gov/21128783

Lynch-Jordan AM, Sil S, Peugh J, Cunningham N, Kashikar-Zuck S, Goldschneider KR. Differential changes in functional disability and pain intensity over the course of psychological treatment for children with chronic pain. *Pain* 2014;155:1955-1961. www.pubmed.gov/24954165

Matos M, Torres R, Santiago R, Jurado M, Rodríguez I. Adaptation of parent-child interaction therapy for Puerto Rican families: a preliminary study. *Fam Process* 2006;45:205-222. www.pubmed.gov/16768019

Miranda J, McGuire TG, Williams DR, Wang P. Mental health in the context of health disparities. *Am J Psychiatry* 2008;165:1102-1108.

Palermo T, Eccleston C, Goldschneider K, Larkin McGinn K, Sethan N, Turner H et al. Assessment and management of children with chronic pain. A position statement from the American Pain Society, 2012. <http://americanpainsociety.org/uploads/get-involved/pediatric-chronic-pain-statement.pdf>

Sue S. In search of cultural competence in psychotherapy and counseling. *Am Psychol* 1998;53:440-448. www.pubmed.gov/9572007

Whaley AL, Davis KE. Cultural competence and evidence-based practice in mental health services: a complementary perspective. *Am Psychol* 2007;62:563-574. www.pubmed.gov/17874897