

**Cultural Genograms: Promoting Cultural Humility, Awareness of Intersecting
Identities, and Transformative Complicity as Prerequisites
To Culturally-Responsive Health Services**

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








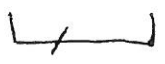
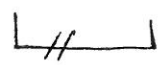



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Suggested Cultural Genogram Symbols

Male	Gender		Foster care
Female			Adoption
Colors	National origin		Covenant relationship
Colors	Ethnicity		Uncovenanted relationship
Colors	Racial identity		Prison
	Religion		Homelessness
\$\$\$ \$ \$	Socioeconomic status		Abortion
	Age at childbirth		Miscarriage / stillbirth
	Separation		
	Divorce		
	Sexual orientation	S	Illness
Forced	Emigration / immigration	D	Disability
Voluntary		X	Death
Forced	Migration within country	A	Addiction
Voluntary		U R	Urban / rural
Compulsory ed	Education		Intercultural relationship
Beyond compulsory			
	War experience		
	Birth order		
X red	Violence		
XX	Loss		
Yellow	Pride		
Purple dots	Ambivalence		
Pink	Shame		

- African Americans in the United States are less likely to receive accurate diagnoses than their Caucasian counterparts. Schizophrenia, for instance has been shown to be over diagnosed in the African American population
- Culture biases against mental health professionals and health care professionals in general prevent many African Americans from accessing care due to prior experiences with historical misdiagnoses, inadequate treatment and a lack of cultural understanding; only 2 percent of psychiatrists, 2 percent of psychologists and 4 percent of social workers in the United States are African American.
- African Americans tend to rely on family, religious and social communities for emotional support rather than turning to health care professionals, even though this may at times be necessary. The health care providers they seek may not be aware of this important aspect of person life.
- Mental illness is frequently stigmatized and misunderstood in the African American community. African Americans are much more likely to seek help through their primary care doctors as opposed to accessing specialty care.
- African Americans are often at a socioeconomic disadvantage in terms of accessing both medical and mental health care: in 2006, one-third of working adult African Americans were uninsured in the preceeding year.
- Experiences of mental illness vary across cultures, and there is a need for improved cultural awareness and competence in the health care and mental health workforce.
- Across a recent 15-year span, suicide rates increased 233 percent among African Americans aged 10-14 compared to 120 percent among Caucasian Americans in the same age group across the same span of time.
- Somatization—the manifestation of physical illnesses related to mental health—occurs at a rate of 15 percent among African Americans and only 9 percent among Caucasian Americans.
- Some studies suggest that African Americans metabolize some medications more slowly than Caucasian Americans, yet they often receive higher doses of psychiatric medications, which may result in increased side effects and decreased medication compliance.
- Social circumstances often serve as an indicator for the likelihood of developing a mental illness. African Americans are disproportionately more likely to experience social circumstances that increase their chances of developing a mental illness.
- African Americans comprise 40 percent of the homeless population and only 12 percent of the U.S. population. People experiencing homelessness are at a greater risk of developing a mental illness.
- Nearly half of all prisoners in the United States are African American. Prison inmates are at a higher risk of developing a mental illness.
- Children in foster care and the child welfare system are more likely to develop mental illnesses. African American children comprise 45 percent of the public foster care population.
- Exposure to violence increases the risk of developing a mental illness; over 25 percent of African American children exposed to violence meet criteria for posttraumatic stress disorder.
- With the implementation of various programs and innovations, African Americans' patronization rates for mental health services may be improved.
- Programs in African American communities sponsored by respected institutions, such as churches and local community groups can increase awareness of mental health issues and resources and decrease the related stigma.
- Programs that improve enrollment rates in safety net health care providers can result in increased mental health care due to improved mental health coverage in the African American community.
- Encouragement in the community to join mental health related professions can increase the number of African American mental health care providers and increase social sensitivity among the provider community.
- Overall sensitivity to African American cultural differences, such as differences in medication metabolism rates, unique views of mental illness and propensity towards experiencing certain mental illnesses, can improve African Americans' treatment experiences and increase utilization of mental health care services.

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Preparing a cultural genogram:

- Draw family members by generation
 - You and your sibs/partners
 - Parent/aunts/uncles
 - Grandparents
 - Children
 - Other important "informal" family members
- Add colors for national origin/ethnicity/racial identity
- Put cultural symbols next to family members
- Provide legend showing symbols you used

Questions to consider for each group constituting your culture of origin (quoted from Hardy & Laszloffy, 1995, p. 232)

1. What were the migration patterns of the group?
2. If other than Native American, under what conditions did your family (or their descendants) enter the United States (immigrant, political refugee, slave, etc.)?
3. What were/are the group's experiences with oppression? What were/are the markers of oppression?
4. What issues divide members within the same group? What are the sources of intragroup conflict?
5. What significance does race, skin color, and hair play within the group?
6. What is/are the dominant religion(s) of the group? What role does religion and spirituality play in the everyday lives of members of the group?
7. What role does regionality and geography play in the group?
8. How are gender roles defined within the group? How is sexual orientation regarded?
9. a) What prejudices or stereotypes does this group have about itself? b) What prejudices and stereotypes do other groups have about this group? c) What prejudices or stereotypes does this group have about other groups?
10. What role (if any) do names play in the group? Are there rules, mores, or rituals governing the assignment of names?
11. How is social class defined in the group?
12. What occupational roles are valued and devalued by the group?
13. What is the relationship between age and the values of the group?
14. How is family defined in the group?
15. How does this group view outsiders in general and mental health professionals specifically?
16. How have the organizing principles of this group shaped your family and its members? What effect have they had on you?
17. What are the ways in which pride/shame issues of each group are manifested in your family system?
18. What impact will these pride/shame issues have on your work with clients from both similar and dissimilar cultural backgrounds?
19. If more than one group comprises your culture of origin, how were the differences negotiated in your family? What were the intergenerational consequences? How has this impacted you personally and as a therapist?

Discussion / Reflection Questions (quoted from Hardy & Laszloffy, 1995, p. 234)

1. What are your family's beliefs and feelings about the group(s) that comprise your culture of origin? What parts of the group(s) do they embrace or reject? How has this influenced your feelings about your cultural identity?
2. What aspects of your culture of origin do you have the most comfort "owning," the most difficulty "owning"?
3. What groups will you have the easiest time working with, the most difficult?
4. Was the exercise valuable, worthwhile? Why or why not?

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