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REVIEW ARTICLE

Psychiatry Resident Training in Cultural Competence: An Educator's Toolkit

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Abstract Resident physicians training in psychiatry in the U.S. are required to master a body of knowledge related to cultural psychiatry; are expected to adopt attitudes that endorse the principles of cultural competence; and finally are expected to acquire specific cultural competence skills that facilitate working effectively with diverse patients. This article first provides an overview of the Accreditation Council for Graduate Medical Education (ACGME) competencies related to cultural competence, as well as the American Academy of Child and Adolescent Psychiatry's (AACAP) recommendations for the cultural competence training of child/adolescent fellows. Next, numerous print and electronic resources that can be used in cultural competence education in psychiatry are reviewed and discussed. Finally, we conclude by providing recommendations for psychiatry residency programs that we culled from model cultural competence curricula.

Keywords Cultural competence · Graduate medical education · Psychiatry

Introduction

As the U.S. population becomes increasingly culturally-diverse, a growing body of evidence highlights cultural differences that impact symptom presentation, diagnosis, assessment, and treatment in psychiatric practice [1]. Consequently, the need for cultural competence education and training in psychiatry has been and continues to be widely-discussed. Indeed, the U.S. Census Bureau has estimated that more than half of all Americans will be racial-ethnic

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minorities by 2044, and that nearly one in five of the nation's population will be foreign born [2]. As we consider a future in which the majority of the US population will consist of racial-ethnic minorities, the need to focus on cultural competence is all the more pressing. Hence, it is essential that we not only continue to educate future psychiatrists in cultural competence, but that we also work to enhance and expand such competence in the manner that no doubt will be needed in the near future.

Over the past few decades, psychiatry has made significant progress in addressing cultural competence. Initially, the field focused on acquiring basic knowledge of cultural factors that impact psychiatric symptom presentation and psychiatric care. Although this was critical, formative work, questions remained regarding how to translate such knowledge into concrete clinical skills and interventions. In addition, many initial cultural competence efforts were reductionist insofar as they unwittingly perpetuated racial-ethnic stereotypes by "presenting lists of [minority] traits for clinicians to remember rather than clarifying the complex socio-cultural environments in which patients live" [3].

The publication of *Outline for Cultural Formulation* (OCF) in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) in 1994 was the first step away from lists of ostensible ethnic-minority "traits" and toward a framework that clinicians could use to organize cultural information relevant to diagnostic assessment and treatment planning [1, 4]. The OCF outlined four assessment domains: 1) cultural identity of the individual, 2) cultural explanations of illness, 3) cultural factors related to psychosocial support and functioning, and 4) cultural elements of the patient-physician relationship. A fifth domain entailed focusing on information influencing diagnosis and treatment [4–6]. The creators of the OCF requested additional guidance from clinicians to translate this outline into a workable cultural formulation, and clinicians provided feedback [1]. Consequently, for the DSM-5, the OCF was revised into the *Cultural Formulation Interview* (CFI) by an international consortium (*The DSM-5 Cultural Issues Subgroup*) to create a standardized interview of 16 questions with guidelines [5]. The CFI was designed to be used by any clinician with any patient in any clinical setting [6].

Specifically, the CFI provides in depth instructions regarding how to ask the questions that will elicit the information required for each part of the OCF. The CFI includes patient and informant versions and 12 supplementary modules addressing specific domains of the OCF [1, 7]. For example, the supplementary CFI module for school-age children and adolescents targets developmental dimensions that are not addressed in other modules (e.g., representations of age-related normality in the child's life environments, age- related stressors and supports, and cultural dimensions of transition to adulthood or maturity) [8]. Given that it is designed in interview format, the CFI is supposed to address critiques that clinicians overly focus on disease pathology and ignore the patient's psychosocial experience of illness. By eliciting the patient's explanatory model and incorporating that into the treatment plan, it is purported that patient satisfaction with treatment and adherence to the treatment plan may both increase [3]. Since the DSM-5, the ability to use the CFI and OCF to create a cultural formulation of a clinical case has become one of the most critical cultural competence skills that residents in psychiatry are expected to master.

At the individual clinician level, achieving cultural competence can be understood as the acquisition of cultural *knowledge* about population subgroups, the adoption of culturally sensitive *attitudes*, and the acquisition cross-cultural *skills*. Alternatively, cultural competence can be understood as encompassing cognitive (e.g., knowledge and awareness), technical (e.g., skills such as cross-cultural communication skills), and attitudinal (e.g., exploration of cultural

and racial preconceptions and attitudes) competence [9]. At the system level, cultural competence can be understood as "the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" [10]. Although these general principles are well-established, the implementation of cultural competence training in psychiatry residency programs is an ongoing challenge. Best practices are still developing, and model curricula have begun to appear only in the past decade.

This article reviews the professional competencies expected by the end of residency training and the educational resources that can be used in cultural competence education in psychiatry. We begin with the Accreditation Council for Graduate Medical Education (ACGME) competency domains related to cultural competence, and conclude with recommendations for psychiatry residency programs drawn from examining "model" cultural competence curricula in the field.

Competencies for Graduation from Residency Training

Of the 27 main specialties and 101 subspecialty programs accredited by the ACGME, psychiatry and its subspecialties (child and adolescent; forensic psychiatry, psychosomatic medicine, geriatric psychiatry, addiction psychiatry, brain injury medicine, hospice and palliative medicine; and sleep medicine) have some of the more intensive and highly-focused cultural competency requirements for training. This also is the case for psychiatry's primary care partners (family medicine, pediatrics, obstetrics and gynecology), as well as for the unique specialty of physical medicine and rehabilitation [11]. The cultural competency framework for educating residents in general psychiatry is housed within five of the six core competency domains (i.e., Patient Care and Procedural Skills; Medical Knowledge; Interpersonal and Communication Skills; Professionalism; and Systems-based Practice), as shown in Table 1. The AGME also provides some guidance to programs on the type and scope of training opportunities that must be offered in order to ensure a learning environment where residents readily can meet the cultural competence milestones that are required to be mastered prior to completion of residency.

These competencies are critical from an education program planning perspective insofar as they outline specifics regarding exactly what kind of knowledge, which skills (i.e., patient care, procedural, interpersonal/communication, system's based practice), and what attitudinal (e.g., professionalism) competencies residents are expected to master before graduation.

In addition to the aforementioned milestones for general psychiatry residency training, the ACGME also provides additional guidelines for some subspecialty fields. For example, Child and Adolescent Psychiatry Fellows are expected to master additional competencies regarding cultural influences on the family and other domains relevant to child/adolescent populations [12]. These milestones were finalized after the general psychiatry milestones (in July of 2015), and only recently have been implemented into many fellowship training programs. Although cultural topics can be included in numerous milestones, they are usually addressed within the core competency of Professionalism. The ACGME and American Board of Psychiatry and Neurology (ABPN) expect that all child and adolescent psychiatry trainees will be competent in their professionalism skillset which includes compassion, integrity,

Table 1 ACGME psychiatry requirements for training related to cultural competence and required program resources

Competency Domain	Description
Patient care and procedural skills IV. A.5.a).(1). (a) and IV. A.5.a).(1). (b)	Residents must demonstrate competence in: the evaluation and treatment of patients of different ages and genders from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds; and must demonstrate competence in forging a therapeutic alliance with patients and their families of all ages and genders, from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds
Medical Knowledge IV. A.5.b).(2) and IV. A.5.b).(9)	Residents must demonstrate competence in their knowledge of: biological, genetic, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle; and aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power
Interpersonal and communication skills IV. A.5.d).(1)	Residents are expected to: Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds (this includes effectively working with interpreters)
Professionalism IV. A.5.e).(5)	Residents are expected to demonstrate: Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
Systems-based Practice IV. A.5.f).(9)	Residents are expected to: Assist patients in dealing with system complexities and disparities in mental health care resources
General Program Requirements	
Resources	The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. Specifically, there should be patients of different ages and genders from across the life cycle and from a variety of ethnic, racial, sociocultural, and economic backgrounds. There should be an inpatient population that is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and genders.

Adapted from http://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf

respect for others, sensitivity to diverse patient populations, and adherence to ethical principles. This milestone underscores that at the completion of the child and adolescent fellowship, trainees should be able to adapt their clinical approach to meet the needs of diverse patients and populations. It also highlights that physicians entering practice should be able to develop mutually agreeable care plans in the context of conflicting physician and patient and/or family values and beliefs.

The American Academy of Child and Adolescent Psychiatry (AACAP) has provided recommendations on cultural competency among Child and Adolescent Psychiatrists and Child and Adolescent Psychiatry Fellows, via their established practice parameters. These, along with a plethora of other resources, are available on the AACAP website. The practice parameters on cultural competency were last updated in October of 2013 [13]. The practice

parameter link for "Cultural Competency" links to a fifteen-page AACAP Action Article that details the expectations for cultural competency among those practicing child and adolescent psychiatry [14]. These expectations or principles were developed after a detailed literature review and incorporate the values that AACAP expects of its members. These thirteen principles are presented in Table 2.

In reviewing these subspecialty principles of cultural competence, there is clear and obvious overlap with the ACGME competencies for general psychiatry, as well as some subspecialty-specific elaboration of knowledge, skills, and attitudes that are expected to be mastered. For example, numbers 8, 9 and 10 in Table 2 highlight specific ways in which cultural understandings of the family system may impact the collection of information regarding a child/adolescent patient's presenting problem, and how this information may influence the treatment plan. Cultural competency principles from other psychiatry subspecialties similarly provide further elaboration of the core ACGME competencies for general psychiatry.

Cultural Competence Training Resources Available in Psychiatry and Allied Fields

Numerous training resources are available to assist educators in creating a comprehensive cultural competence training program within their psychiatry residency program. Independent reading is typically a core aspect of didactic instruction. Hence, Table 3 summarizes a few textbooks that can serve as essential readings.

Table 2 AACAP principles related to cultural competence

1. Clinicians should identify and address barriers (economic, geographic, insurance, cultural beliefs, stigma, etc.) that may prevent culturally diverse children and their families from obtaining mental health services.
2. Clinicians should conduct the evaluation in the language in which the child and family are proficient.
3. Clinicians should understand the impact of dual-language competence on the child's adaptation and functioning.
4. Clinicians should be cognizant that cultural biases might interfere with their clinical judgment and work toward addressing these biases.
5. Clinicians should apply knowledge of cultural differences in developmental progression, idiomatic expressions of distress, and symptomatic presentation for different disorders to the clinical formulation and diagnosis.
6. Clinicians should assess for a history of immigration-related loss or trauma and community trauma (violence, abuse) in the child and family and address these concerns in treatment.
7. Clinicians should evaluate and address in treatment the acculturation level and presence of acculturation stress and intergenerational acculturation family conflict in diverse children and families.
8. Clinicians should make special efforts to include family members and key members of traditional extended families, such as grandparents or other elders, in assessment, treatment planning, and treatment.
9. Clinicians should evaluate and incorporate cultural strengths (including values, beliefs, and attitudes) in their treatment interventions to enhance the child's and family's participation in treatment and its effectiveness.
10. Clinicians should treat culturally diverse children and their families in familiar settings within their communities whenever possible.
11. Clinicians should support parents to develop appropriate behavioral management skills consonant with their cultural values and beliefs.
12. Clinicians should preferentially use evidence-based psychological and pharmacologic interventions specific for the ethnic/ racial population of the child and family they are serving.
13. Clinicians should identify ethnopharmacologic factors (pharmacogenomic, dietary, use of herbal cures) that may influence the child's response to medications or experience of side effects.

Adapted from: [14]

Table 3 Sample textbooks relevant to cultural competence in psychiatry, published since 2000

Intended for psychiatry audience

Alarcon, R. D. and Wise, T. N. (2013). *Cultural Psychiatry (Advances in Psychosomatic Medicine, Vol. 33), 1st Edition.* S. Karger. Basel, Switzerland.

Bhattacharya, R., Cross, S., and Bhugra, D. (2010). *Clinical Topics in Cultural Psychiatry.* RCPsych Publications. London, UK.

Bhugra, D. and Bhui, K. (2011). *Textbook of Cultural Psychiatry.* Cambridge University Press. Cambridge, UK.

Committee on Cultural Psychiatry of the Group for the Advancement of Psychiatry. (2002). *Cultural Assessment in Clinical Psychiatry.* American Psychiatric Association Publishing, Washington, DC.

Kirmayer, L. J., Lemelson, R., and Cummings, C.A. (2015). *Re-Visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health.* Cambridge University Press. New York, NY.

Lim, R. F. (2014). *Clinical Manual of Cultural Psychiatry: Second Edition.* American Psychiatric Publishing, Inc. Washington, DC.

Tseng, W. (2003). *Clinicians Guide to Cultural Psychiatry.* Academic Press. San Diego, CA.

Tseng, W. and Streltzer, J. (2004). *Cultural Competence in Clinical Psychiatry.* American Psychiatric Publishing, Inc. Washington, DC.

Intended for other mental health fields

Hayes, P.A. (2016). *Addressing Cultural Complexities in Practice: Assessment, Diagnosis, and Therapy*, Third Edition. American Psychological Association, Washington, DC.

Heine, S.J. (2015). *Cultural Psychology, Third Edition.* W. W. Norton & Company, New York, NY.

Kitayama, S. (2010). *Handbook of Cultural Psychology.* The Guilford Press, New York, NY.

Tseng, W. and Streltzer, J. (2008). *Cultural Competence in Health Care*. Springer, New York, NY.

On the whole, textbooks on the topic present and organize cultural information separately for each ethnic group (e.g., African-Americans, Latinos [15, 16]). Other approaches, such as organizing cultural information in terms of the clinical setting in which psychiatrists work (e.g., inpatient, outpatient, emergency [17]) are less common. More recent texts are moving away from the norm of presenting information group by group, to a more integrated focus on interdisciplinary understandings of culture that are relevant to all groups worldwide (e.g., [18]). Strengths that are common across texts include the use of case scenarios that elaborate and highlight cultural issues. One important limitation of current texts is that some are written from a European perspective (e.g., [19, 20]), and hence may be less generalizable to US populations. Another source of concern about many textbooks is that they focus almost exclusively on providing information about cultures and ethnic groups (i.e., knowledge), and provide less emphasis on the related clinical skills that residents are expected to master. Moreover, the ACGME competency domains for cultural competency (Table 1) include aspects of diversity beyond race/ethnicity (e.g., socioeconomic diversity, LGBT issues, age, gender, religion, and disability). Since most of the available texts are focused on culture only (i.e., cultural psychiatry), no current textbook in psychiatry incorporates this entire spectrum of diverse groups, although some recent texts come close [16]. More comprehensive texts on cultural competence (vs. cultural knowledge) are needed and would be beneficial to training programs.

Consequently, supplemental materials are often used in combination with race-ethnicity focused texts. Such materials address ethnopsychopharmacology, socioeconomic diversity, gender identity and sexual orientation diversity, disability, other aspects of diversity, and their treatment implications. In addition to textbooks and supplementary readings, web resources

can be used in mixed-method approaches that incorporate both independent learning activities and interactive teaching approaches during didactic time (e.g., case discussions, simulations, peer instruction, etc.). Table 4 provides a list of web resources that educators may find useful.

Finally, one advanced skill in cultural competence is the ability to critically evaluate the literature on cultural and other diversity topics. Initially, this may involve introducing residents to the sources of the science base in each of the major cultural competence domains. Table 5 provides an overview of several academic journals in the area of cultural psychiatry, as well as some complementary academic journals in cultural psychology. The authors use such lists to generate resident interest in new work in this field. For example, distributing a new article that complements the didactic content can elicit enthusiastic interest in cultural psychiatry and cultural competence. Similarly, familiarizing residents with diverse journals can encourage inclusion of articles in mainstream didactic experiences that are not specifically labeled as "cultural" (e.g., selecting a culturally-relevant article for discussion in journal club in response to new cultural competence questions that arise during clinical practice).

The resources summarized here are not comprehensive, but are instead a snapshot of available resources. Subspecialists are encouraged to search their professional organization websites for additional resources specific to their subspecialty. For example, for child/adolescent psychiatrists, there is a "Systems of Care Toolkit" on the AACP website that has an eighteen page module on cultural considerations in systems-based practice [21]. This module was recently revised (in March of 2016) and provides a detailed review of cultural considerations for child and adolescent psychiatrists who work with youth in systems such as in primary health care, education, child welfare, and juvenile justice. In addition to defining and explaining the role of the child and adolescent psychiatrist in cultural competent healthcare, sample cases for discussion are also provided in this online module, making this an excellent teaching tool for educators.

Table 4 Sample web resources for teaching cultural competence in psychiatry

Resource	Website(s)
American psychiatric association: best practice highlights for treating diverse patient populations (videos)	https://www.psychiatry.org/psychiatrists/cultural-competency/treating-diverse-patient-populations
Columbia university medical center: center of excellence for cultural competence	http://columbiapsychiatry.org/research/centers/cultural-competence http://nyculturalcompetence.org/videos/
Society for the study of psychiatry and culture	https://psychiatryandculture.org/resources/
American psychological association: training videos on gender and sexual minority issues	http://www.apa.org/apags/governance/subcommittees/lgbt-training.aspx
American psychological association: multicultural training database	http://www.apa.org/apags/governance/subcommittees/cultural-competency.aspx
American psychological association: multicultural counseling videos	http://www.apa.org/pubs/videos/browse.aspx?query=series:Multicultural%20Counseling
U.S. department of health and human services: a physician's practical guide to culturally competent care	https://cccm.thinkculturalhealth.hhs.gov/
National center for cultural competence	http://www.clcpa.info/

Table 5 Sample journals relevant to cultural psychiatry: sources of the science base

Journal	Publisher	Website
Intended for psychiatry audience		
Culture, medicine, and psychiatry	Springer	http://www.springer.com/social+sciences/anthropology+%26+archaeology/journal/11013
Transcultural psychiatry	Sage	http://tps.sagepub.com/content/by/year
World cultural psychiatry research review	World association of cultural psychiatry	http://www.wcprr.org/
Intended for other mental health and medical fields		
Cultural diversity and ethnic minority psychology	American psychological association	http://www.apa.org/pubs/journals/cdp/
Culture & psychology	Sage	http://cap.sagepub.com/
International journal of cultural psychology	Journal network	http://www.journalnetwork.org/journals/international-journal-of-cultural-psychology
International journal of culture and mental health	Taylor & Francis	http://www.tandfonline.com/toc/rccm20/current
Journal of cross-cultural psychology	Sage	http://jcc.sagepub.com/

Suggestions for Residency Programs: Lessons from Sample Curriculums

Given the scope of the training goals for cultural competence that are set by the ACGME, and the wealth of resources available to educators to meet these goals, it is beneficial to examine "model" curricula in the field as examples of the strategies that programs use to weave the various aspects of required training into a comprehensive whole. Table 6 provides a list of model curricula.

Table 6 Sample model curriculums for cultural competence training in psychiatry

Resource	Website(s)
A guide to incorporating cultural competency into health professionals' education and training	http://njms.rutgers.edu/culweb/medical/documents/CulturalCompetencyGuide.pdf
American academy of child and adolescent psychiatry: diversity and cultural competency curriculum for child and adolescent psychiatry training	https://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/diversity_and_cultural_competency_curriculum/Overview_Final_Cultural_Competency_Curriculum_for_CAP_Training.pdf
University of California, Davis: a four-year model curriculum on culture, gender, lgbt, religion, and spirituality for general psychiatry residency training programs in the united states	http://www.ucdmc.ucdavis.edu/psychiatry/aboutus/dac/cultural_competence_curriculum.pdf
American academy of child and adolescent psychiatry: diversity and cultural competency curriculum for child and adolescent psychiatry training	http://www.aacap.org/aacap/resources_for_primary_care/Diversity_and_Cultural_Competency_Curriculum/Home.aspx
The association of LGBTQ psychiatrists: group for advancement of psychiatry (gap) lgbt online curriculum	http://www.aglp.org/gap/

An examination review of these sample curricula reveals a few critical points. First, most highlight the need to approach cultural competency training across all years of the program (i.e., cultural competence is a dynamic set of knowledge, attitudes, and skills that cannot be mastered in a single isolated didactic experience at a single time point). Likewise, most assume that competency develops in a developmental fashion, i.e., trainees must first master foundational knowledge/attitudes/skills before they can master higher-order ones.

For example, Table 7 summarizes the developmental trajectory of knowledge, attitudes, and skills that are expected of residents at different levels of training, based on a model curriculum from the University of California Davis [22]. As shown, there is a shift from an emphasis on knowledge/attitudes in the earlier stages of training towards a greater emphasis on skills at advanced levels of training. Finally, it also is noteworthy to see that, consistent with the ACGME guidelines, truly comprehensive training in cultural competence must also include the development of knowledge, attitudes, and skills related to areas of diversity beyond race/ethnicity.

With the exception of the UC-Davis curriculum, most other model curricula focus on culture alone, highlighting that there is a paucity of models for the other areas of diversity. The LGBT Issues Committee of the Group for Advancement of Psychiatry (GAP) does have an 8-module online curriculum for cultural competence with LGBT populations [23]. The syllabus includes modules on 1) The History of Psychiatry and Homosexuality; 2) Taking a Sexual History with LGBT Patients; 3) Psychological Development and Life Cycle, 4) Psychotherapy; 5) Medical and Mental Health, 6) Transgender; 7) Intersex, and 8) Diversity/People of Color. While this is a valuable resource for this topic, integration of this content with other cultural competence materials is left up to the educator, since it is presently designed as a stand-alone resource.

Hence, in earlier stages of training, where increasing the trainee's knowledge base is the goal, it is important that educators carefully select well-rounded readings. Reliance on available textbooks alone is not recommended, given that the majority focus only race/ethnicity and do not include information about other types of diverse groups. Incorporation of web-based instruction, or journal-based readings may be an alternative method to fully cover the entire spectrum of diversity that falls under the cultural competence umbrella. At more advanced levels of training, a focus on providing opportunities for practicing requisite skills in a safe environment is suggested. Recent evidence supports the idea that trainees prefer hands-on experiences versus passive instruction. For example, in a recent study examining the implementation of the DSM-5 cultural formulation model, clinicians reported a preference for case-based behavioral simulations (an active learning strategy) as "most helpful" to attain mastery, in contrast to watching videos alone (a passive learning strategy) [5].

As we look to the future, it is clear that more work is needed to fully integrate cultural competence training into all aspects of graduate education in psychiatry. To fully meet the ACGME training goals, integration should take place in training across treatment modalities, from psychopharmacology to psychotherapy; across stages of development, from early childhood development to geriatric stage (and death and dying); for all clinical sites from inpatient care to community mental health care; and for all special populations, including incarcerated persons, military persons, and persons with intellectual disabilities. Residency programs also should enhance opportunities for residents to critically appraise literature addressing sociocultural factors in clinical practice. One possible challenge for educators is a lack of familiarity with the knowledge, attitudes, and skills that encompass cultural competence, as many senior

Table 7 Developmental trajectory of cultural competence skills[22]

Knowledge & attitudes	*Skills*
Beginning level	
Definition of common terms: *culture, cultural competency, race, ethnicity, religion, spirituality*	Identify potential barriers to therapeutic engagement related to cultural differences between self and patients
Understand one's own cultural identity	
Understand how culture impacts symptom presentation, health beliefs, help-seeking, and decision-making	
Understand the impact of racism, sexism, heterosexism, ageism, and religious/ spiritual bias on diverse patient groups	
Develop awareness and acceptance of differences between one's own worldview and those of others	
Intermediate level	
Develop culturally specific knowledge (*example: common cultural beliefs, gender and family roles, religious/ spiritual practices*) related to patient populations (*example: local African Americans, Asian immigrants, Latino migrant workers, LGBT college students,* etc.) generally seen within the clinical training environments	Understand and review DSM-5 Glossary of Cultural Concepts of Distress Understand and review DSM-5 Cultural Formulation Understand the effect of race, if any, on psychopharmacology
Understand the difference between healthy and normative spiritual or religious beliefs and practices from that which are unhealthy and/or psychopathological	Identify cultural stressors in a patient case
Appreciate and value patients' spirituality/ religious beliefs and practices which offer a source of strength/ hope/ coping	Begin to incorporate the cultural issues including spiritual/ religious and sexual orientation/ gender identity into the differential diagnosis and case formulation
Advanced level	
Understand the appropriate use of cultural/ spiritual consultants, non-medical care providers, and other resources	Appropriately apply terms from the DSM-5 Glossary of Cultural Concepts of Distress
Understand the impact of spiritual/ religious beliefs and practices for end of life issues	Participate in discussion of DSM-5 Cultural Formulation
Understand and address transference and counter-transference that may occur when exploring cultural issues with patients and its effect on therapy	Conduct aspects of the DSM-5 Cultural Formulation Interview and write up/ present a cultural case formulation
	Understand and apply structured spiritual assessments
	Formulate psychotherapy cases by incorporation of cultural themes (*racial identity, ethnic identity, sexual orientation, gender identity, acculturation,* etc.)
	Critically assess research on spirituality and health care
	Critically assess research on disparities in care for vulnerable populations

educators may not have experienced the in-depth education on this topic that is required of learners today during their own training. Hence, there is a great need for educators and learners alike to have a broad array of training resources available to them.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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