

# Affirmative Care Across Cultures: Broadening Application

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Affirmative practice is an approach to health and behavioral health care that validates and supports the identities stated or expressed by those served. Affirmative care requires the practitioner to actively honor and celebrate identity while at the same time validating the oppression felt by individuals seeking services. Validation and empathy fundamentally result from increased understanding of individuals' history, cultural context, and lived experiences. Origins of the approach honored the experience of those in LGBTQ+ communities; however, affirmative care should be valued

across cultures, systems, and settings in which health and behavioral health care are offered. Affirmative care principles should be applied across cultures and communities while recognizing the worth of the individual and avoiding stereotyping. Along with delineating historical and demographic contexts, the authors offer recommendations for affirmative care in practice with African American, Asian, Indigenous, and Latinx individuals, as well as those living in rural communities.

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Affirmative care is defined as an approach to health care delivery in which organizations, programs, and providers recognize, validate, and support the identity stated or expressed by the individuals served (1). Affirmative or affirming care has been recognized as a best-practice form of service for lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) people (2, 3). This model of care for members of sexual and gender minority communities is much preferred over approaches that pathologize LGBTQ+ individuals or attempt to cis-heteronormatively convert their identities and preferences.

In this article, we provide an overview of affirming care principles proposed for LGBTQ+ communities, drawing parallels between these principles and best-practice guidelines for other minoritized communities such as individuals from racial and ethnic backgrounds traditionally disadvantaged in the United States. We seek to build on elements of the American Psychiatric Association's web series, "Best Practice Highlights for Treating Diverse Patient Populations" (4) and to share practical information on particular identity groups' demographics, some historical focus, information related to disparities and stigma, and specific affirmative recommendations to inform treatment.

## FOUNDATION: AFFIRMATIVE CARE PRINCIPLES

Affirmative practice refers to a range of models that serve to create safe and supportive health care environments in

which individuals can express their identity (5). The movement toward affirmative practice began in the late 1970s and early 1980s (6); it was founded on the assumption that sexuality and gender identity different from heterosexual and cisgender experience were normal and, moreover, that acknowledging and affirming identity and experience was a critical component of helping clients integrate their identity with the rest of their lived experience (5). In a recent review of the historical roots of affirmative practice, Gates and Kelly asserted, "Affirmative and strengths-based practice blends the micro, mezzo, and macro by supporting LGBTQ individuals while actively speaking out when individuals, groups, institutions, and communities treat them with less than the full dignity they deserve" (5, p. 236).

Fundamentally, affirmative practice is both active celebration and activist in its manifestation. It requires practitioners to actively affirm and honor identity while at the same time validating the oppression felt by the individual seeking services. Offering further clarification (in the context of transgender care), Austin and Craig (7) asserted that affirmative clinical practice must acknowledge and counter the oppressive contexts in which clients experience care. Understanding and empathizing with the felt discrimination, otherness, microaggressions, and victimization experienced by individual clients is critical to the role of the affirmative practitioner. In sum, affirmative application includes contextualizing

identity and developing safe, supportive, and identity-affirming networks (7).

Furthering their work related to affirmative care, Austin et al. (8) offered specific practice recommendations for therapy with transgender and gender-nonconforming adults. Of note, they clarified that minority stress may lead to high levels of stigma related to mental disorders. Moreover, because transgender and gender-nonconforming adults are arguably marginalized, they are vulnerable to social stressors; Austin et al. aligned this thinking with the experience of persons of color. Specifically, referring to the work of Bryant-Davis and Ocampo (9), they wrote,

When persons of color encounter racial prejudice, regardless of whether these events involve actual or threatened death, they experience cognitive and affective assaults on identity that permeate their core sense of themselves. . . . [Similarly], an affirming and trauma-informed perspective recognizes that traumatic events and experiences, including non-life-threatening forms of transphobic prejudice, threaten . . . clients' sense of safety and undermine self-determination. (8, p. 142)

Through a lens of affirmative care, practitioners are able to honor the individual's experience in the context of known power structures and oppression. At the same time, practitioners are celebrating all identities with which individuals align. In the following sections pertaining to affirmative care with African-American, Asian, Indigenous, and Latinx people and rural communities, we assert that the affirmative care lens has broad application across cultural spectrums. Empathic response within a given cultural context may look different from individual to individual and may require (e.g.) basic practitioner knowledge of language, historical trauma, within-group diversity, suspicion, reluctance to trust care providers, and traditional cultural beliefs. Moreover, providers must consider interpersonal power dynamics related to roles, expertise, age, and body language while at the same time understanding the higher-level power structures that oppress and stigmatize people of color and vulnerable groups. Affirmative care means considering all of these and more as a starting place and contextual foundation on which to celebrate and honor all identities as with which people present in health and behavioral health practice.

## AFFIRMATIVE CARE WITH INDIVIDUALS

Affirmative care is a means to celebrate and honor the individual. Individual clients or patients may identify strongly with a particular culture or cultures. Conversely, treating a client as though they identify strongly with a particular culture when they do not may produce the effect opposite to what practitioners seek, which is to better empathize with the person seeking service. We acknowledge and recognize the critical stance that cultural competence programs may actually serve to reinforce stereotypes (10). Malat advocated for practitioners to fully comprehend the individual experience to ultimately reduce racial disparity in practice (10).

Aligned with Malat's thinking, Hansen et al. (11) described the tension that arises as a function of necessary cultural competency and suggested an antidote in the form of structural competency. Said another way, the etiology of marginalization is systemic in nature and not easily addressed by learning more about a given culture. In the attempt to create space and give voice to expertise about a given culture, we certainly run the risk of creating tension. There is a boundary we will not cross—namely, we do not intend to reinforce stereotypes. Rather, we seek to highlight how affirmative practice might take shape in a given cultural or geographical context. We do not seek to be exclusionary; we seek only to forward the knowledge available to us. In the following sections, we draw from our own practice and experience (in the context of culture) to offer both abstract and tangible advice for those seeking to affirm individuals in their environment and within the context of their culture.

## AFRICAN-AMERICAN COMMUNITIES

### Background for Practice

Fundamentally, health and behavioral health providers seeking to conduct affirmative practice may consider understanding historical context a first step. Historically, African Americans have not had the right to control what happens to their bodies. Arguably, this plays out on television whenever there is a shooting involving an African American and a police officer. Authority figures (e.g., law enforcement, government, military) have too often taken advantage of power positions, taking away the basic right to control what happens to African-American bodies. Medicine, as an institution, is comparably guilty, fostering a level of mistrust that makes it difficult for African Americans to take part in medical care to the same extent as people in other communities.

Many see the division between the African-American community and medicine as having started with the Tuskegee syphilis study, which continued from 1932 to 1972; however, a division existed well before that (12). Science was a part of the ideology behind the institution of slavery. Science posited that African Americans were less intelligent, did not experience pain, were subhuman, and were immune to illnesses, thus making them perfect for field labor (13). Because African Americans were considered property, consent was not needed to use the African-American body to conduct research. Surgical procedures for reproductive health were infamously carried out on African-American women with little concern for the bodies that were being used. Procedures were at times conducted without the use of anesthesia, because the individual was believed to not feel pain, and without regard for basic human decencies (14). At least one physician who carried out such atrocities was later elected the president of the American Medical Association, rather than being penalized. The psychiatric diagnosis of drapetomania, or runaway slave syndrome, was used to pathologize any slave who had the audacity to flee their situation (15). During the Reconstruction era, doctors argued that the

minds of former slaves could not cope psychologically with freedom, and thus African Americans would not thrive in a free society (16). Moreover, rather than recognizing the institutional forces that tended to separate African-American families, they argued that African Americans were not interested in family. Thus, even before the erosion of trust associated with the Tuskegee syphilis study, African Americans already distrusted a system in which they were often made to feel less than human.

Today, disparity persists. African Americans are almost three times more likely to die of asthma than are white Americans (17). African Americans have a 25% higher cancer death rate than white Americans (18). Moreover, African Americans continue to have a shorter life expectancy than white Americans (19). Given these historical and modern experiences, is it any surprise that studies have shown that African Americans are much less likely to report trust in their physicians (16)? This lack of trust contributes to poor health outcomes because African Americans will often not seek out treatment early in a disease process when treatment might be more beneficial (20).

Many authors have speculated that an increase in the number of minority health care providers will go a long way to mend some of the loss of trust (21). However, this is merely window dressing and not nearly enough. The institution of medicine remains far separated from the African-American community; by the time a person has gone through the education necessary to become a provider, he or she is cultivated to be an outsider. Medicine has far too often absorbed individuals from different cultures and changed them to reflect the culture of medicine rather than adapting to the cultures that it intends to treat. To be affirmative in African-American communities, providers must not only look like those in the community but must still be able to share an interest and investment in that community.

### **Affirmative Care in Practice**

Affirmative care means that professionals working in health and behavioral health fields must be educated in empathy and individual experience. Professionals must move beyond the evidence base and examine application as it relates to the individual. Taking the time to learn about culture is critical. The experience and values of African Americans may be very different from the experience and values of a black individual from another background or country. Similarly, the African-American culture in Baltimore can look quite different from the African-American culture in New Orleans or Los Angeles. Providers must be able to communicate in a way that respects the concerns of the individual as an important part of the treatment plan.

Ultimately, access to care must be equal to be affirmative, so that individuals see that they receive the same care as their white counterparts. African-American families are disproportionately affected by the economics that make health care a luxury and not a right. In sum, affirmative care assumes that everyone should have the right to live a healthy life and control their own body.

## **ASIAN COMMUNITIES**

### **Background for Practice**

Asian Americans are a vast, heterogeneous group, and understanding various cultural differences is critical to affirmative practice. The term *Asian* refers to people with origins in the Far East, Southeast Asia, the Indian subcontinent, and the Pacific Islands, including, for example, China, India, Japan, Korea, Malaysia, Pakistan, the Philippines, Samoa, Thailand, and Indochina. Each Asian-American group has its own language, culture, and health beliefs. Within each group, depending on geography, dialect, custom, and subculture, there are also subgroups. The 2017 US Census estimated that there are 17.6 million Asians and 1.3 million Native Hawaiian and Pacific Islanders in the United States—about 6% of the estimated US population of 316.4 million. The three largest Asian-American groups are Chinese, Asian Indian, and Filipino. In this article, we discuss practice recommendations in the context of these Asian-American groups given the cultural expertise of the contributing author. However, practitioners are asked to view each person within the context of their, her, or his own culture as an individual who may articulate their, her, or his experience in myriad ways.

### **Affirmative Care in Practice**

The following recommendations for practice, adapted from Gaw's (author) earlier work, are aligned with affirmative care principles in psychiatric settings.

Practitioners should consider the potential for a language barrier. A non-English-speaking person will need an interpreter. Translation requires extra time, so physicians should plan ahead if an interpreter is needed, and schedule extra time for the interview. When seeking an interpreter, physicians should ask for one who speaks the patient's specific dialect. Clinicians must use short, simple sentences to facilitate translation by the interpreter and void using technical words such as *anxiety*, *depression*, *somatization*, and *psychosis*; rather, physicians should describe the illnesses they are asking about by using their signs and symptoms. Interpreters should be instructed to translate exactly what the physician is asking for and not to introject their own ideas.

Practitioners may consider involving the family in health care decisions (22, 23). Family members may accompany the patient for diagnostic interview and follow-up treatments. If the patient asks to include family in the process, explaining the patient's issues to both the patient and the family helps to build their understanding of psychiatric disorders, achieving mental health, and promoting adherence to treatment plans.

As part of their cultural formulation, physicians should ask about traditional beliefs. Sophistication in understanding mental disorders varies among individuals from different cultures, depending on their degree of acculturation, educational background, and familiarity with the Western system of medical care. For example, older, non-English-speaking, unacculturated Chinese immigrants may hold

traditional values and concepts of health and disease (e.g., yin-yang) and express their mental distress through somatic symptoms. Immigrant patients from a rural area of Vietnam may believe in ghosts and express their symptoms as evidence of possession by ghosts or evil spirits. Asian Indians and Filipinos may carry strong religious beliefs about their mental illness and may seek religious healing methods and trust traditional healers. It is useful to ask individual patients about their ideas of mental illness and treatments to effectively formulate diagnostic considerations and treatment plans that would be more acceptable to them.

It is critical that clinicians become familiar with ethnopsychopharmacological research (24). Asians, for example, have been found to have mutated enzymes that affect the metabolism of psychotropic drugs. *Physicians' Desk Reference* drug dosages may not be appropriate for some Asians who are poor metabolizers. For example, it may be necessary to start with a lower prescribed dosage of psychotropic medications for Asians.

Patients should be asked to bring all medications to initial and follow-up clinic visits to check for accuracy and effects of medications taken and for potential drug-drug interactions. Also, many non-English-speaking as well as older patients take multiple medications and may not know or remember their names.

Be attentive to comorbid medical problems. Many older psychiatric patients may have comorbid physical conditions such as hypertension, diabetes, hyperlipidemia, or cardiac and kidney problems that may affect their mental state. By paying attention to both physical and mental health problems, practitioners can enhance adherence to diagnostic and treatment programs and promote their role as providers of holistic care.

Practitioners should also consider traditional healing interventions. Asian-American immigrants may be familiar with Tai Chi, breathing exercises, acupuncture, and other traditional stress reduction and relaxation techniques, and their prescription should be encouraged. The combined use of herbal and Western medications should be discouraged.

Ask for a detailed clinical history using open-ended questions. During a physician interview, Asian patients may claim mental wellness out of courtesy when, in fact, they may still have concerns and issues that need to be explored and be treated.

The pragmatic steps outlined in this section offer an example of affirmative care in action. For Asian patients or clients, action relays validity and has the potential to help the provider demonstrate empathy. Although these steps are broadly described here, cultural consideration must include appreciation of the individual and diversity of experience.

## INDIGENOUS COMMUNITIES

### Background for Practice

Being affirmative with Indigenous people means understanding the current standpoint and history of the settlement and

colonization of North America. Indigenous people on Turtle Island, or North America, have a rich diversity of language, cultures, and histories. Currently, 573 American Indian tribes are federally recognized in the United States (25), with a population of 325,719,178 (26), just more than 2% of the U.S. population. In Canada, there are nearly 1.7 million aboriginal people. Indigenous people in North America may call themselves Indigenous, Native American, American Indian, Alaska Native, Native Hawaiian, Inuit, Métis, First Nations, or Aboriginal, and they will often identify themselves as being from a specific nation or village.

More than 15 million people lived in North America before contact, and they spoke more than 300 distinct languages (27). Genocidal practices have been inflicted on Indigenous groups from the time of contact up until today with the epidemic of missing and murdered Indigenous women and girls. Colonization consisted of genocidal practices and forced relocation of Indigenous peoples (28). This history is significant in the rupture of Indigenous families through, to name one example, forced separation of children from their parents to attend boarding schools. The colonization and settlement of North America had the goal of either extermination of the Indigenous people or cultural genocide.

Indigenous people have struggled to maintain their cultural identity, language, and religion since contact with settlers. Many Indigenous peoples were imprisoned for practicing their ceremonies, such as the potlatch in Canada and the Sun Dance in the United States (26). Historical events in the United States and Canada included the development of governmental genocidal policies that were established with intent to “kill the Indian in him and save the man” (29). The man who spoke these words was Brigadier General Richard H. Pratt, the superintendent of the Carlisle Industrial Indian School, the first Indian boarding school, which opened in 1879 in Carlisle, Pennsylvania (30). These boarding schools, which were under U.S. government authority, supported the destruction of the Indigenous child’s culture, language, and spirituality through the involuntary process of assimilation. If families refused to let their child attend these schools, their rations were withheld (31). In Canada, more than 6,000 First Nations, Métis, and Inuit children died while under the care of residential schools. The Truth and Reconciliation Commission of Canada’s final report, released in 2015, concluded that “cultural genocide was the intent” of the residential school system (32).

Multiple generations of Indigenous families continue to be affected by intergenerational trauma of families being torn apart, children dying in care of schools, and cultural practices being disrupted (32). Higher rates of substance use, attachment disorders, posttraumatic stress disorder, and suicide have been directly associated with intergenerational trauma among Indigenous peoples (33). Lakota psychologist Maria Yellow Horse Brave Heart coined the term *historical trauma*, which refers to the cumulative emotional and psychological wounding over the lifespan and across

generations emanating from massive group trauma. It occurs when a group's existence is threatened through loss of culture, identity, or land and results from the persecution of a group of people on the basis of their culture or identity. Historical trauma has occurred within Indigenous communities in the disruption in traditional forms of support and parenting of children; the result has been a higher risk for mental health challenges (34, 35). The traumas of loss of identity, land, and culture put Indigenous peoples at higher risk of mental health challenges (33).

### **Affirmative Care in Practice**

Affirmative care with Indigenous patients or clients involves understanding the history of a given Indigenous community while honoring the individual experience. Assessment and evaluation should be thorough to avoid stereotypes and misdiagnosis and paced so as to not be hurried or rushed. The focus should be on meeting patients where they are. Said another way, providers are encouraged to allow patients to tell their story and to share their cultural identity. Providers should acknowledge the presence of intergenerational trauma, including the loss of sacred lands and spiritual practices, family disruption, and forced assimilation. Moreover, affirmative care involves validating patients' unique experiences, cultural background, and resilience and strength as survivors. When providing psychological care to Indigenous peoples, providers should incorporate culturally relevant treatments when appropriate and support them in their cultural practices (36). Indigenous communities that provide traditional programs that incorporate culturally relevant activities such as drumming, sweat lodges, beading, and Indigenous cooking help to promote healthy identities and pride. For example, Dr. Daniel Dickerson (37), an Inupiat psychiatrist, incorporated Indigenous drumming into substance abuse treatment programs. Two positive themes emerged: Cultural ways, traditions, and values were found to be extremely important in the mental, physical, spiritual, and emotional health of Indigenous persons and Indigenous tradition-based healing practices have significant potential to improve mental health.

Affirming care may also be enhanced by having a receptive and inviting environment, such as including art that reflects cultural aesthetics and acts as a mirror so patients feel respected and valued. In the psychological evaluation, clinicians should pace interviews with patients and validate their story. Timing is extremely important to establish trust and rapport; it may also help clinicians avoid the pitfalls of stereotypes or assumptions. For example, clinicians should avoid assuming that Indigenous peoples do or do not practice native spiritual practices or that those who do not speak their native language are less Indigenous. With respect to Navajo people, for example, churches have been established in the heart of the Navajo nation in which many people have been converted to a specific religion, yet they speak only Navajo and wear traditional attire and may even reject their Navajo philosophy and teachings.

Self-identity is very important to Indigenous peoples. Thus, providers may ask patients or clients to introduce

themselves, noting their identity as an Indigenous person from a specific nation or nations. It is insensitive to refer to a self-identified Navajo person, whose blood quantum may be half Navajo, as half Navajo and half White, for example. Providers can also ask about history and culture in a sensitive manner. Note that some families deal with confidentiality in different ways, and some elders expect to be involved in treatment planning. Providers should, of course, ask for permission first. Affirmative care for Indigenous peoples is integral to positive mental health outcomes.

## **LATINX COMMUNITIES**

### **Background for Practice**

As of July 2017, the U.S. Census Bureau estimated the national Latinx population to be 58.9 million, constituting 18.1% of the nation's total population (26). About three-fourths of US-born Latinxs are third generation or higher (38). Most of the U.S. Latinx population is composed of people of Mexican, Puerto Rican, Salvadoran, or Cuban background (39). Incorporating affirmative care in the mental health care of Latinx communities is critical because these communities are instrumental in helping society thrive.

Consideration of social determinants of health is critical to understanding disparities in mental health care for the Latinx community, including environmental-societal structures of education and economic stability, physical characteristics of the environment (neighborhood), community and interpersonal contexts, and social-cognitive-behavioral stress and cultural factors (40). An investigation of the prevalence of everyday discrimination found differences by ethnicity (i.e., Cubans were less likely to report discrimination), by age (negative association), nativity, and English language proficiency (41). A review of the research on more than 10 years of state-level immigration policies in the United States identified the pathways between the structural racism of these policies and individual stress and its direct impact on mental health, because these same policies also prohibit access to services. In the best of circumstances, evidence-based treatment includes attention to culture. Latinx mental health researchers who have developed cultural adaptations of mental health interventions have reported barriers to research (i.e., methodology, political climate, funding priorities, intellectual isolation) and identified the importance of working intensively with communities to develop cultural adaptations and cultural enhancements of interventions (42).

Multiple barriers exist for Latinxs when it comes to accessing health care, particularly mental health care. About 20% of Latinxs do not have health insurance, possibly because of their immigration status, lack of employment benefits, or limited financial means, increasing the likelihood of their not seeking care because of high health care costs. Sociocultural stigma surrounding mental illness might be another significant barrier to seeking mental health care for Latinxs (37). Moreover, Latinxs might be hesitant to seek mental health care because they have experienced a lack of

psychological trust, safety, and security as a result of anti-immigrant discrimination and ethno-racial trauma or because of fear of deportation if a family member is undocumented (43, 44). Given these contexts, we offer recommendations for affirmative care.

### Affirmative Care in Practice

Affirmative care with Latinx communities involves practicing with cultural humility to understand beliefs, values, and abilities while also validating that social disparities, discrimination, and racism have an impact on well-being. The cultural formulation model (CFM) (45) is a framework for engaging in collaborative dialogue with patients that is respectful of cultural beliefs and values, pays attention to the relevant and central aspects of their stories, and includes framing culturally focused questions to facilitate understanding the patient's needs, priorities, preferences, and resources. The CFM includes the following constructs: cultural identity, understanding explanatory models, and identifying supportive cultural networks and cultural factors that influence help-seeking. We refer the reader to Fortuna et al. (46) for an in-depth discussion.

Practitioners exploring affirmative care with Latinx and other communities of color may benefit from the use of narrative and collaborative practice to address inequalities. It has been claimed that the work of reauthoring identity helps people identify their own values and the skills and knowledge they need so that they can apply them to healing and identifying solutions. Narrative therapy focuses on assisting people to construct their own story about their identity that is helpful to them, and it is effective with Latinx and immigrant populations (47). Narrative therapy in a family setting allows use of the technique of externalizing problems to facilitate positive interaction. Seeing a problem objectively helps families reconnect with the heart of their relationship (i.e., immigration is a problem, but it is not who we are; we are . . .). They then address how the problem has challenged the core strength of their bond and move toward coping and supporting their familial well-being.

Collaborative decision making is a process of engagement in which provider and patients (and their loved ones) work together, using information to understand clinical issues and to determine the best course of action. Moving beyond the two-way knowledge exchange proposed in the shared decision-making model, the exchange of information leads to the development of a stronger partnership between the patient and the provider (48). The first step is creating a strong patient-provider relationship in which traditionally disenfranchised communities are respected. Community-health care partnerships in which mental health professionals work with Latinx service agencies can help bridge the gaps in access to care and create opportunities to integrate interventions in trusted community organizations. In addition, health care and mental health services institutions are more successful when they practice multiculturalism and value inclusion and respect, cultural and language

accessibility, and care for immigrants. The most affirmative approach to improve the care offered to the Latinx community is to build systems that allow for this collaborative response to community and individual needs rather than simply responding via stereotype-driven formulas.

## RURAL COMMUNITIES

### Background for Practice

Affirmative care practitioners are called on to respond to community need in consideration of ecological context. The concept of rural, often narrowly defined in the medical literature by government census criteria of population density, is much broader and significant, and it is interwoven with the country's founding, history, and ongoing development (49). The term *rural* is frequently defined in contrast to *urban*; for rural residents, however, it is not a universal for a setting outside of a major population center but a specific location fashioned by geography, history, peoples, and community. The challenge in proffering guidance, found in all work with special populations, is to discuss generally shared trends among rural populations while emphasizing the uniqueness of individual rural communities. The most important advice for the clinician interested in rural work may be to approach each community with a beginner's mindset to learn about the community, its peoples, and environmental contexts.

Although the overall prevalence of mental health conditions is comparable between urban and rural communities, the impact, types of conditions, services, and resources are not. Notably, suicide is higher in rural areas, and rural communities are disproportionately challenged by the opioid epidemic, as evidenced by high death rates, level of opioid prescriptions, and fewer targeted treatment resources (50). Ultimately, affirmative care in rural community means accessibility, availability, and acceptability. Acceptability refers to how rural inhabitants feel about seeking mental health care. Furthermore, stigma related to mental health is a pervasive issue in both urban and rural communities and is cited as a significant barrier to care. Perceptions of privacy, confidentiality, and dual relationships in smaller communities can make rural patients more reluctant to seek the help that they need (51).

The Western Interstate Commission for Higher Education Mental Health Programs uses the rubric of accessibility, availability, and acceptability to characterize the system-level challenges facing rural mental health (52). Accessibility issues include not only geographical distance to care but the challenges imposed by the environment. For example, a three-hour drive to access mental health care in the Northern Plains in the summer can turn to an all-day endeavor during a winter storm. Once care has been reached, rural populations often face barriers in navigating systems and receiving culturally appropriate care. Availability speaks to the mental health workforce challenges, which are much greater in rural areas where struggles with

chronic shortages and understaffing are common. It is challenging to recruit a national psychiatric workforce that is largely urban and trained in urban settings to rural areas; a lack of familiarity with rural cultural systems can create hesitation because of the perception that opportunities for continued professional growth and development are lacking (53).

Technology in general and telepsychiatry, in the form of videoconferencing, in specific are often proffered as a solution to increase accessibility and availability of rural mental health services, but they come with their own set of issues. Although telepsychiatry can increase access, it does not in itself increase the psychiatric workforce; rather, it virtually redistributes the existing workforce. Rural communities may compete to receive telepsychiatry both with other rural communities and, increasingly, with urban areas. In addition, health care technology creates digital disparities; many rural communities and residents struggle to cross the digital divide to obtain adequate broadband (54). Telepsychiatry uses remote providers, often urban based, who are less likely to be familiar with local systems, resources, and cultures, potentially affecting the quality and level of care tailored to an individual patient. Complex health and mental health care funding issues affect the resources available to rural communities to develop mental health services.

In addition to becoming aware of disparities and access issues in rural communities, health and behavioral health care providers should also be aware of some general trends. Gun ownership is more prevalent in rural areas, and attitudes toward and the meaning of gun ownership can be significantly different. Gun ownership may form a core part of an individual's identity, including hunting traditions and concepts and ideas of individual rights and responsibilities. Practitioners should be aware of these trends and be comfortable having respectful dialogues about gun safety and firearms management, especially when managing suicidal patients (55). Dual relationships are more common in small communities and can affect psychiatrists living in the community in which they work.

### **Affirmative Care in Practice**

To be affirmative, health and behavioral health care providers should become familiar with best practices for managing and navigating dual relationships for themselves and become comfortable with working to create enhanced feelings of privacy and confidentiality for patients in small communities. Practitioners should seek mentorship and specific consultation when significant boundary issues arise (56).

Clinicians working with and in rural communities should commit to becoming serious students of their communities (57), beginning with learning about the history, resources, cultures, and systems present in the community in which they are working. Providers should recognize that even in a specific rural community, the culture is not monolithic; individual patients, like all patients, represent macro and micro cultural influences. Seeking out local facilitators and mentors for guidance and education about the local culture

is invaluable. Several examples exist of specific psychiatric services that use cultural navigators in rural environments to educate providers, engage patients, and better tailor care (58). Health and behavioral health care providers working remotely should work to garner an awareness of local community events, festivals, and significant issues through site visits, community news, and local staff. If providers are not working in their home community, small demonstrations of local knowledge go a long way to facilitate rapport with patients and decrease the view of providers as outsiders. Concepts of time are often more nuanced, with events, and the perception of correct timing for events (alignment of the right people to the right situation), being dictated as much by the clock as by the seasons. Community events both joyous and tragic have wide ripple effects throughout a small community, affecting individual and collective mental health. Awareness of these events as they occur can help providers understand environmental stressors and issues affecting patients.

Opportunities for affirmative practice abound for providers interested in engaging in work with rural communities. For psychiatrists (in particular) there exists a plethora of ongoing recruitment opportunities to live in and work with rural communities anywhere in the country. For those not wanting to relocate to a rural environment, telepsychiatry provides a way to serve these populations. In addition, emerging in-person and telepsychiatric models of team-based care, such as integrated behavioral health in a primary care setting, allow providers to care for a wider population of patients and help to address workforce and resource issues. In sum, many resources exist to bring patients closer to health and behavioral health care, affirming space, place, and identity.

### **CONCLUSIONS**

Affirmative care in practice is essentially valuing, honoring, and celebrating identity, given the myriad ways in which an individual exists within a culture, even—and especially—when their experience includes being oppressed and stigmatized. Although the origins of affirmative care aligned with a cultural shift toward honoring the experience of those in LGBTQ+ communities, the approach is valued across cultures, systems, and settings in which health and behavioral health care are offered.

Across all cultures discussed in this article, several universal affirmative practice truths emerge. First, it is clear that histories and associated traumas must be taken into account, along with individuals' lived experience, especially when those traumas are related to the physical or mental health of generations (e.g., slavery). Moreover, historical traumas differ within cultures, and the expression of trauma may vary from generation to generation. The manifestation of historical trauma can take many shapes in health care practice, but it may appear as distrust or reluctance to engage. To address potential barriers to affirmative care, we

have sometimes given very specific recommendations related to affirmative practice; at other times, recommendations are more amorphous, calling on practitioners to understand more about the identities of the persons with whom they interact.

To be clear, affirmative practice is not merely learning more about the identities of patients or clients served. Affirmative practice is activist in nature, meaning there is an inherent appreciation of the power structures that prejudice, oppress, and stigmatize. It is not enough to acknowledge a patient's or client's cultural experience. Practitioners are called on to affirm patient experiences through validation, including the active involvement of forces outside the individual to play a role in the care of the individual (e.g., family members, traditional healing practices). They are called on to culturally celebrate (e.g., with art) in the physical plant of the health or behavioral health care setting. They are called on to make use of narrative therapy to help patients author or reauthor identity. Ultimately, as voiced in the "Rural Communities" section, health and behavioral health providers must be "serious students of their communities" (57) while at the same time recognizing that each and every individual comes equipped with multiple ways of knowing and standing in the world, often at the intersection of multiple identities and roles. It is the work of the health or behavioral health practitioner to empathize, validate, advocate, and celebrate the experience of clients from multiple intersecting backgrounds.

#### AUTHOR AND ARTICLE INFORMATION

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