



Culturally competent care for nontraditional family structures

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KEYWORDS:

Cultural competency;
Multicultural;
Same-gender parents;
Same-sex parents;
Transracial adoption;
International adoption;
Grandfamilies;
Multigenerational

Cultural competency applies not only to minority ethnic or religious groups but also to nontraditional family structures. A review of the evidence-based literature and clinical practice tips will be highlighted for the following family types: children being raised in multicultural or bilingual families, children of same-gender parents, children being raised by grandparents or in multigenerational families, and transracial adopted children. Same-sex parenting alone does not appear to be a risk factor for poor outcomes in children. There is no statistical certainty that distinguishes the developmental, psychological, or social outcomes of children raised by same-gender parents to that of children raised by opposite gender parents, when socioeconomic levels of the families are equal. Conversely, children raised by grandparents have an increased incidence of behavioral and emotional disturbances and therefore may require extra attention to mental health needs. Grandparents may face many challenges when they unexpectedly have to step in to care for a grandchild: housing difficulties, financial, feelings of guilt or grief, loss of independence, and work limitation, thus, the grandparents themselves have an increased likelihood of depression and several other chronic medical conditions. There have been a vast number of studies on domestic and international adoption, which demonstrate that transracial adoption itself does not place a child at a higher risk for emotional and behavioral problems. Children of racial or ethnic minorities who are adopted into a family of the ethnic or racial majority, however, are at a potential risk for ethnic-identity confusion. Feelings of discrimination and ethnic-identity confusion appear to be less prevalent in transracial adopted children whose parents engage in a variety of cultural socialization strategies. Hispanics are more likely than non-Hispanic whites to live in multicultural households. Certain child-rearing practices may be interpreted as abusive if the provider is unfamiliar with the family's culture, thus being familiar with the cultural practices of the most common local ethnicities is critical. Utilization of professionally trained medical interpreters if bilingual providers are not available can assist with language barriers as well as clarification of cultural beliefs. As the family physicians of these children and their parents or caregivers, we not only need to be informed about and be sensitive to their special concerns, but also have a responsibility to incorporate current evidence-based information in our approach.

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Introduction

Throughout our training and careers, we study diligently about hundreds of medical conditions, diagnostics, and treatments. As family physicians, we learn and pride ourselves on the importance of treating the whole person. Obtaining a comprehensive social history is ingrained in

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our minds as an important component of providing comprehensive health care to our patients, to have the full perspective of patient needs, circumstances, and risk factors. At times, we sense the patient or family or both may not see that correlation, and we feel the need to preface, clarify, and assure confidentiality, so as to put them at ease before disclosing personal information, which includes their family structure. Do we, however, approach and respond in a culturally competent manner? Cultural competency can be defined as, "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."¹ In health care, we commonly think of cultural competency as applied to minority ethnic or religious groups,² but there are other minority social groups toward which the concept must also be applied, including nontraditional family structures. Identifying and addressing the special health and societal challenges of each of the following family types will be addressed in this article: children being raised in multicultural or bilingual families, children of same-gender parents, children being raised by grandparents or in multigenerational families, and transracial adopted children. As the family physicians of these children and their parents or caregivers, we not only need to be informed about and sensitive to their special concerns, but we have a responsibility to incorporate current evidence-based information in our approach.

Same-gender parents

According to the 2011 US Census' American Community Survey, an estimated 605,472 same-sex couples' households live in the United States, and 16% of these reported having at least 1 biological, step, or adopted child under the age of 18 years living in their household.³ In addition, it is estimated that over 2 million children have a gay or lesbian parent.⁴ Now, let us consider a routine check of a child in which you learn your pediatric patient is being raised by same-gender parents. In our role to support their optimal health and development, the family physician may instinctively develop concern for the possible negative effect this family structure may have on the patient's whole person. Should you consider this is a risk factor for social, developmental, and physical problems? Should you bring forth a special skill set or approach to the encounter per se? Should an individual or family counseling referral be part of your standard plan of care for this family structure? Before responding with subjective assumptions and intuitive recommendations, be sure you are familiar with outcomes data on this subject to guide your approach. Reviews of the evidence-based literature indicate that same-sex parenting alone does not appear to be a risk factor for poor outcomes in children, yet this family structure does indeed face challenges that can become serious barriers to the optimal health and development of its children.

In 2010, Michael Rosenfeld, of Stanford University's Department of Sociology, analyzed a large sampling of US census data and published a comparison of the progress through primary school of children raised by same-gender parents and children raised by other family structures. Although his analysis indicated that children raised by lesbian and gay parents were held back a grade at a higher rate (9.5%-9.7%) compared with that of heterosexual married parents (6.8%), Rosenfeld elaborates that parental socioeconomic status accounted for at least 50% of that relatively small 2.9% delta, factoring that heterosexual married parents are typically more economically prosperous.⁵ He further points that the rates of grade retention amongst children of same-sex parents were lower than that of children of heterosexual nonmarried parents (11.7%) and children of single parents (11.1%-12.6%), and were significantly lower in comparison with both the 34.4% rate of grade retention amongst children raised in an orphanage or other group setting and the 78% rate amongst children who were in prison.⁵ In addition, Rosenfeld reviewed 45 empirical outcome studies of children raised by same-gender parents, and none demonstrated any inherent developmental disadvantage with statistical significance. Rosenfeld's conclusion was "children of same-sex couples are as likely to make normal progress through school as the children of most other family structures."⁵

A U.S. national longitudinal study demonstrated that adolescents who had been reared in lesbian families since birth demonstrated healthy psychological and social adjustment. Of the 78 children studied from birth till 17 years of age, they were "rated significantly higher in social, school or academic, and total competence and significantly lower in social problems, rule-breaking, aggressive, and externalizing problem behavior than their age-matched counterparts."⁶ The American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health's *Technical Report: Coparent or Second-Parent Adoption by Same-Sex Parents* found that "the weight of evidence gathered during several decades using diverse samples and methodologies is persuasive in demonstrating that there is no systematic difference between gay and nongay parents in emotional health, parenting skills, and attitudes toward parenting. No data have pointed to any risk to children as a result of growing up in a family with 1 or more gay parents."⁷ In a 2008 comparative study conducted by the psychology department of University of Virginia, 88 adolescents of matching demographics were drawn from a national sample, with 50% of them raised by same-gender female parents and the other 50% by heterosexual parents. "On both self-reported and peer-reported measures of relations with peers, adolescents were functioning well, and the quality of their peer relations was not associated with family type. Regardless of family type, adolescents whose parents described closer relationships with them reported higher quality peer relations and more friends in school and were rated as more central in their friendship networks."⁸ Thus, when parental socioeconomic statuses are neutral, there is

no statistical certainty that distinguishes the developmental, psychological, or social outcomes of children raised by same-gender parents.

There are, however, numerous legal and health disparities faced by same-gender couples, which can negatively affect the physical and emotional development of their children. Compared with heterosexual couples, same-gender couples are 50%-75% less likely to have health insurance, as employers are not legally required to offer health benefits to same-gender spouses or partners or their children. As at least two-thirds of children have the same health insurance status as their parents, this creates a barrier to quality health care for these children.⁴ Furthermore, the inconsistency in recognition of parental rights can lead to the prohibition of gay or lesbian parents from accompanying or consenting or both to routine or emergent treatment of their children. The disparity of reactions of health care providers is vast, ranging from acceptance to contempt. In some cases, the fear of stigmatized attitudes, discrimination, mistreatment, or blame for their child's medical problems leads to the reluctance of same-gender parents to seek medical care for their children.⁴ In addition to the legal acceptance of parental rights and access to health insurance, the permanence and security of marriage can foster the optimal development of a child.⁹ According to the American Academy of Pediatrics Task Force on the family, married persons have a greater life expectancy, lower rates of substance abuse, and a tendency to have a higher social support system.¹⁰ In a 2009 survey to analyze the effect of marriage equality, 135 out of 153 same-gender parents responded that their children were happier or better off since their marriage.¹¹ Although 35 respondents noted that their children had previously been teased or taunted about having a gay or lesbian parent, only 7 reported their child had been teased about their parents' same-gender wedding or marriage.¹¹ On the contrary, there were some instances in that their children's peers perceived them as "being cool for having married gay parents."¹¹ In 2013, the American Academy of Pediatric's *Committee On Psychosocial Aspects Of Child And Family Health* published a technical report emphasizing it is "important to recognize that laws restricting competent adults of the same gender from codifying their commitment to each other and their children via civil marriage may result not only in pain and hardship for their children but also in legal, economic, psychological, social, and health disparities that can no longer be justified."¹²

Recommendations or resources

Health care providers treating children with same-sex parents should aim the following:

- Offer a welcoming environment for same-gender parents and their children.
- Approach the history-taking process in an empathetic and nonjudgmental manner. Ask open-ended questions about psychological health, school progress, and social

interaction, looking for red flags that may need physician intervention without suggesting a problem simply based on parental structure.

- Include all parents and key caregivers in discussions about the child's health care, so as to capture the combined efforts. According to the Joint Commission's position, health care providers should "discuss a child's care with both parents when possible, including cocustodial parents and same-sex parents, even if both do not have legal custody."¹⁵
- Encourage same-gender parents to secure legal parental arrangements and rights to limit potential barriers to optimal health care interactions.⁹
- Provide affirmation that same-gender parents' consideration of marriage improves security and development for their child.⁹
- American Civil Liberties Union is a resource for second-parent adoption regulations by state: <https://www.aclu.org/lgbt-rights/lgbt-parenting>.¹³
- Encourage parents to help their children cope with pressures and be prepared for discrimination by:
 - "Preparing how to handle questions and comments about their background or family.
 - Allow for open communication and discussions that are appropriate to your child's age and level of maturity.
 - Help your child come up with and practice appropriate responses to teasing or mean remarks.
 - Use books, Web sites and movies that show children in LGBT families.
 - Consider having a support network for your child (For example, having your child meet other children with gay parents.)
 - Consider living in a community where diversity is more accepted."¹⁴

Multigenerational or grandfamilies

Payten, a 22-month-old female, presents for her 18 month well child visit with her grandmother. As Grandma explains, Payten's mother has been in some trouble with the law regarding drug possession and "intent to distribute." You know from previous visits that Dad has not been involved with Payten since shortly after birth. Grandma tells you that Payten will be staying with her "until her mother gets her life straightened out." When you ask Grandma later in the visit what type of dwelling they live in, she becomes agitated, and then tearful, and then says they are looking for a place to stay because the Senior apartment that has been her home for 10 years does not allow children. She also admits they are pretty tight on money and that she has had to take a part-time job while Payten is in daycare to make ends meet. Payten is a happy child and Grandma thinks she has done well overall with the transition. As the nurses prepare Payten's vaccinations and Grandma attempts to get mom on the phone to provide consent, you go back to your office to gather some resources to help Payten and Grandma with some challenges of their new living arrangement.

Since 1980, the number of households in the United States containing family members from more than 2 generations has been on the rise.¹⁶ From 1990 to 2008, the number of multigenerational family households increased from 35 to 49 million.¹⁶ From 2000 to 2010, there was a 30% increase in families in the United States in which children live with their parents and grandparents. Although more common in minority ethnic groups, especially Hispanics, the trend can be generalized to all ethnicities. Many factors have contributed to this trend, including increased longevity, divorce, job loss, and home foreclosures.¹⁶ Among multigenerational families, there are 3 different subtypes. Forty-seven percent of multigenerational families are made up of 2 adult generations living together, that is, grown child living with parents, or elderly parent living with grown child. Another 47% are made up of 3 or more generations in the same household, that is, middle-aged adult with child and grandchild. The remaining 6% of multigenerational families are made up of 2 skipped generations, that is, grandmother raising grandchild with the child's parents not present in the home.¹⁶ This unique family arrangement, commonly and hereafter termed grandfamilies, is the focus of this section.

According to the most recent data from the Census Bureau, there are about 2.7 million grandparents who are primarily responsible for the care of their grandchildren.¹⁷ There are many parental factors that bring about this unique living arrangement, including maternal incarceration, divorce, death of parents, maternal mental health problems, abandonment, financial difficulties, and neglect or abuse.^{18,19} Due in part to the difficult family circumstances that often lead to their living with grandparents, these children have increased incidence of behavioral and emotional disturbances,²⁰ and therefore may require extra attention to mental health needs. This living arrangement can be stressful for the children, and also certainly for the grandparents, who may face many challenges when they unexpectedly have to step in to care for a grandchild. Grandparents may have housing difficulties, as some retirement apartments do not allow children. They may not be financially prepared to raise a child. There may be disappointment, guilt, or grief about the circumstances involving the child who has left them in charge of the grandchild. The grandparent may lose his or her independence and ability to work. These added stressors lead to increased likelihood of depression and several other chronic medical conditions in grandparents who are raising their grandchildren, including diabetes and hypertension.^{18,21} Grandparents often face difficulty in school enrollment, obtaining health insurance for the grandchild, and in obtaining legal custody.

Legal or health

When grandparents unexpectedly become the caregivers for their grandchildren, they are often quickly faced with challenges related to their lack of a formal legal relationship with the child. This can present barriers in obtaining health insurance and health care for the child, and also in school

enrollment.²² The options to obtain authority include guardianship, legal custody, and adoption and may become costly because of legal fees.¹⁹ Some insurance companies require proof of relationship or even proof of legal custody to enroll a child on the grandparents' policy.²³

Adoption is the most permanent option as it terminates all rights including legal and financial responsibilities of the parents.²⁴ Guardianship and legal custody are less permanent, as the parent can later petition the court to regain custody of the child, but they do allow the caregiver to make decisions and access services for the child.²⁴ Some states recognize "de facto" custody, which gives family caregivers the status of legal custodian if the child has lived with them for 6-12 months. Relative or "kinship" foster care is another legal option, but in this case, as with regular foster care, the child is in the custody of the state.^{22,24} Subsidized guardianship is a way for children in relative foster care to exit the foster system and come under the guardianship of their relative caregiver. The option for states to fund subsidized guardianship came about with the passing into federal law of the Fostering Connections to Success and Increasing Adoptions Act of 2008.²⁴ Some states have medical and educational consent laws that allow family caregivers to obtain medical care and school enrollment for children even without legal custody.^{23,24}

Finances or housing

Financial and housing difficulties may also be faced by grandparent caregivers. They may not have the space or financial means to support a grandchild. Some senior housing facilities do not allow children, and grandparents may need to look for alternate housing arrangements, as in our case example.²⁴ Grandparents may be living on fixed incomes, and not have the additional funds available to house and feed and clothe a grandchild. Financial assistance may be available in various forms for grandparents raising grandchildren. Subsidized guardianship as mentioned previously is an option for relative foster "parents" to become legal guardians of the child and receive financial assistance. Funds may be available for adoption assistance, especially if the child has special needs.²⁴ Federal funds may be available through Temporary Assistance for Needy Families, regardless of whether caregivers are in the foster care system.^{24,25} In 2003, Congress approved the "Demonstration Program for Elderly Housing for Intergenerational Families" with the purpose of expanding "the supply of intergenerational dwelling units for very low-income grandparent(s) or relative(s) heads of household 62 years of age or older raising a child."²⁶

Recommendations or resources

After we make ourselves aware of the challenges that grandfamilies and other multigenerational families may face, we must prepare ourselves to help equip these families

to succeed. Here are a few points that the physicians should follow:

- Advise grandparents to learn about the laws in their state regarding obtaining custody or guardianship, or adopting their grandchildren.
- Refer to resources for additional assistance:
 - The Generations United website, www.gu.org, is a comprehensive resource for multigenerational families. Among the many useful links is the database of “GrandFacts,” which are fact sheets for each state that list resources with names, phone numbers, and email addresses for local contacts that support grandfamilies. Also listed are local programs, financial assistance, educational assistance, and state laws regarding foster care and kinship care.
 - The American Association of Retired Persons Grandfamilies Guide at www.aarp.org.
 - The Brookdale Foundation Group's Relatives as Parents Program at www.brookdalefoundation.org.
 - The Grandparents State Law and Policy Resource center at www.grandfamilies.org. There, one can also access information about the National Family Care giver Support Program, for which federal funding was approved in November 2000. This program provides monies to the states to fund Area Agencies on Aging, which in turn provide support services for grand parents who are raising grandchildren.²⁷

Transracial adoption

According to the US State Department statistics, the number of international adoptions from 1999-2012 was 242,602.²⁸ As family physicians, we are now more likely than ever to provide care to adopted children who are of a different race or ethnicity than their parents. We naturally think about the traditional clinical considerations, such as preadoption exposures and screenings, as well as ethnic-specific growth or genetic factors. We also need to be well versed on whether there are psychological consequences of growing up in a transracial adoptive family and how the unique experiences of transracial adoptees can affect the child's development of a racial or ethnic identity or both. There have been a vast number of studies on domestic and international adoption, which demonstrate that transracial adoption itself does not place a child at a higher risk for emotional and behavioral problems. In a published multi-literature review, the rate of transracial adoptees with serious behavioral and emotional problems was comparable to same-race adopted and nonadopted children.²⁹ There was no significant difference in levels of distress, self-esteem, and socialization from same-race adoptees and nonadoptees in a 20-year cross-sectional comparison study of 53 Chinese adoptees.³⁰ Birth country, age at adoption, adverse experiences before adoption, and gender do appear to be

contributing factors to those children with long-term behavioral and emotional problems.²⁹

Children of racial or ethnic minorities who are adopted into a family of the ethnic or racial majority, however, are at a potential risk for ethnic-identity confusion. For example, a child of Chinese descent adopted by an American “white” family may be perceived by others in society as Chinese with questions about their ethnicity, language, and heritage being presented in childhood and adulthood. Among the 51 adult transracial adoptees in a cross-sectional survey study, those who looked ethnically or racially different than their adoptive parents were more likely to identify with their adoptive parents' culture than ethnic culture, which correlated with less distress.³¹ Feelings of discrimination and ethnic-identity confusion appear to be less prevalent in transracial adopted children whose parents engage in a variety of cultural socialization strategies. Such strategies include the process of *enculturation*, which is the belief and practice of fostering a positive ethnic identity through ethnicity-specific experiences. In addition, the process of *cultural socialization* is the parental transmission of cultural customs, behaviors, beliefs, and expectations.³²

Recommendations or resources

- Encourage parents to explore techniques of enculturation and cultural socialization.
- Refer parents to resources to learn how to promote a healthy and positive ethnic identity in their child.
 - U.S. Dept. of Health and Human Resources: https://www.childwelfare.gov/adoption/adopt_parenting/

Multicultural

Mariana Martinez, a 4 y/o female, presents to your clinic for ER follow up. She is accompanied by her Caucasian mother and Hispanic father, 2 younger siblings, and an older Hispanic female who you assume is grandma. You have already reviewed her chart and know that she was seen in the ER 2 days prior for cough, runny nose, and fever and diagnosed with a URI. Initially, you begin the visit attempting to communicate with the family in English and your broken Spanish, but you quickly realize that this is ineffective with Dad and Grandma. You bring in your bilingual staff member to interpret. Mom reports that the ER physician recommended that she give Mariana lots of water to drink during her illness. Grandma, however, will not allow mom to give Mariana any cold liquids to drink, and has been making her “te de manzanilla” (chamomile tea) and covering her with Vicks VapoRub at nighttime. Mom is concerned because the cough persists, although the fever has resolved, and she really thinks Mariana needs an antibiotic. Grandma expresses her agreement. You examine Mariana, and then launch into your explanation that this is a viral illness and antibiotics are not necessary. At the end of the visit, you know that you have made the right medical decision, but you realize that both you and the family were dissatisfied with the encounter. Later in the day, you have time to debrief with your interpreter, and learn that as the family

was leaving, grandma told dad in Spanish that she would go to the tienda and purchase the needed antibiotics.

Multicultural households are also becoming more numerous in the United States. According to the most recent Census data, there are over 6 million people in America who live in households with family members from 2 or more races. Parents who have different cultural backgrounds bring to the family unit unique foundational beliefs, ideas, and experiences about child-rearing, development, health, and health care. These families may have challenges with language as well as other cultural barriers. Some traditional practices may be erroneously interpreted by providers as abusive if they are not familiar with the culture. Some of the cultural beliefs influencing health care in Hispanics specifically, as the largest minority in the United States,³³ are addressed later in the article.

Language barrier

There are over 60 million US households in which English is not the primary language spoken in the home.³⁴ Office interventions to increase access for and improve care of patients with limited English proficiency include bilingual or foreign-language handouts, in-office interpreters or bilingual staff, bilingual providers, and telephone access to interpreters. The use of professionally trained medical interpreters (rather than family or friends not trained in medical interpreting) improves the quality of care and patient satisfaction for patients with low English proficiency.³⁴

Traditional practices and abuse

Certain child-rearing practices may be interpreted as abusive if the provider is unfamiliar with the family's culture. For example, in West African cultures, threaded beads are placed around the waist of young girls at puberty as a sign of the beginning of their sexual maturation.¹⁴ These beads can sometimes leave bruises if pressed into the skin beneath the clothes, which can be misinterpreted as signs of physical abuse if the patient is not wearing the beads at the time of the exam.²³ Koramoa et al²³ presented a continuum of child care practices ranging from harmful to neutral to beneficial that gives insight into the broad range of cultural traditions that the practitioner may encounter if he or she asks the appropriate questions. Harmful practices include female genital mutilation and anal and genital insertions for punishment.²³ Neutral practices include threaded beads as described earlier, and gently squeezing the bridge of a baby's nose to prevent nasal congestion and snoring.²³ Beneficial practices that promote wellness and cultural identity include breastfeeding, ceremonial washing of the newborn, and teaching culturally appropriate manners.^{36,23} All of these practices, and others, must be interpreted in the context of the parents' culture in determining what is

harmful, potentially harmful, neutral, or beneficial to the child.²³

Hispanic cultural health care beliefs

Here, we address some challenges related to understanding and treating specifically Hispanic or Latino patients, as they are by far the largest and fastest growing minority currently in the United States.³³ The terms Hispanic and Latino are often used interchangeably, and do overlap significantly. According to the Oxford dictionary, Hispanic refers to people from Spanish-speaking countries (including Spain), whereas Latino refers to people from Latin America (including Brazil, eg, where Spanish is not the primary language spoken).^{37,38} Both terms are used later in the article. There are almost 52 million people in the United States who identify themselves as Hispanic or Latino.³⁹ Health disparities among this group are evident, with an increased incidence of diabetes and obesity,³³ and the highest uninsured rate of any racial or ethnic group in the United States.⁴⁰ With this large and rapidly growing population and their increased medical need, it would benefit family physicians to become educated about cultural beliefs that may affect the way they approach health care.

Family (familia) is central to the Hispanic life.⁴¹ This has many positive effects on child-rearing, but it can pose a challenge in health care when patients seek and follow the advice of older family members over the advice of the physician. Hispanics are also more likely than non-Hispanic whites to live in multicultural households.¹⁶ This brings up healthy and enriching opportunities for children to be surrounded by and raised by multiple caring adults. It may also mean that the family member bringing the child to his or her appointment may not be the parent, or that several family caregivers are present at the visit. Curanderismo is another Hispanic tradition. If family cannot offer advice to cure a patient's complaint, he or she may seek the treatment of the healer (curandero). The curandero's role is to divine what the patient has done to cause the illness or condition to arise, and use specific rituals to eradicate the "spell," "fright," or "evil eye."^{41,42} Conditions and treatments may be categorized by the curandero as either "hot" or "cold," and treated accordingly.⁴³ For example, colic, a "cold" illness might be treated with peppermint, a "hot" herbal remedy. Or, in our case example, Mariana's grandmother was treating her URI, a "cold" illness with hot liquids and eucalyptus, both "hot" treatments. Giving her cold liquids to drink or walking in bare feet would be contraindicated as they could exacerbate a "cold" illness.⁴² In addition to the curandero, an important medical figure in the Hispanic culture is the Promotor de Salud (health promoter). Promotores are lay health workers in the Hispanic community who promote healthy behaviors, and provide screening and health education.⁴⁴ Respect (respeto), trust (confianza), and modesty (modestia) are additional key

aspects of Hispanic culture that are crucial to successful patient-physician interaction.^{43,45}

Additionally, we have noted in our practice and found corroborated in the literature, the tendency for Latino patients to treat common infections with antibiotics acquired without a prescription from stores in the United States or from family members in their countries of origin, rather than seeking medical care for what they perceive as common infections.⁴⁶ This structure has implications for inappropriate use of antibiotics, leading to increased adverse reactions and antibiotic resistance. Antibiotics are relatively easy to obtain in many Latin American countries without a doctor visit or a prescription.⁴⁶ This experience coupled with the fact that Latin American patients are more likely to think their child's illness requires an antibiotic,⁴⁷ increases demand for antibiotics without prescription in the United States. Patients report purchasing these antibiotics from Latino stores (tiendas or bodegas) here in the United States, or having family members bring or send them medications from their home country.⁴⁶ Although the research shows that Latino patients are more likely to seek evaluation by a medical professional if it is their child instead of themselves who is ill,⁴⁶ well-child and acute care visits are still important opportunities for the family physician to use to educate the patients on this topic. Educating Latino patients regarding the potential harms, and lack of benefit from antibiotic use in nonbacterial infections may be effective in decreasing their use of antibiotics without prescription, but more research is needed in this area to define effective interventions.⁴⁸

Recommendations or resources

When caring for a child who is being raised in a multicultural household, or in a culture different from the provider's, it may become essential for the provider to inform him or herself about that culture to provide excellent care. Language is just one of the barriers that may be encountered in this type of patient interaction.

- We suggest that providers utilize professionally trained medical interpreters if bilingual providers are not available.³⁵
- To differentiate harmless cultural practices from abusive ones, we recommend that providers make themselves familiar with the cultural practices of the most common ethnicities in their area, and have resources available to learn about others.²³
- In caring for Hispanic or Latino patients, we suggest the following:
 - Greet all family members when you enter the exam room, and try to involve everyone in the interview.
 - Learn and honor their values of *confianza*, *respeto*, and *modestia*.
 - Become at least loosely familiar with the “hot” and “cold” concept of disease. You may be surprised how

often it will come up in interviews if you are looking for it, that is, moms advising their daughters not to walk barefoot on the floor after delivering a baby; parents telling their children not to go outside and breathe in cold air or drink cold liquids when they have a respiratory illness.

- As always, ask what kinds of treatments they have been giving the child at home. You may need to ask specifically about *hierbas* (herbs). It may also help to ask what they think caused their child to become ill, or why they think he or she is not improving.

Lastly, we recommend taking the opportunity, at well and sick visits, to educate Latino parents on appropriate and inappropriate use of antibiotics, and the risks and benefits.

Conclusion

It is almost certain that in each of our careers, we have already or will at some point or both care for patients from these various family structures. Whether or not there are increased health risks or needs in these populations, it is incumbent on us as family physicians to become culturally competent about these family types to be equipped to provide them the best care possible. Children thrive in many different family situations, and we must do our part to identify risks or barriers to give them the best chance for success.

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