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Clinical care across cultures: What helps, what hinders, what to do

Margarita Alegria, PhD.^{a,b}, Kiara Alvarez, PhD.^a, and Irene Falgas-Bague, PhD.^c

^aDisparities Research Unit, Department of Medicine, Massachusetts General Hospital and Harvard Medical School, Boston, MA 02114 USA

^bDepartment of Psychiatry, Harvard Medical School

^cVall d'Hebrón University Hospital, Department of Psychiatry and Forensic Medicine Universitat Autònoma de Barcelona, Barcelona, Spain

Today's clinicians must develop therapeutic alliances with patients of diverse customs, values, and experiences. This can be especially challenging, as most clinicians must make decisions quickly, opening the door to systematic attributional errors and untested assumptions about patients without confirming that their expectations are correct. In one study, white therapists were more likely than Chinese therapists to describe Chinese patients as depressed with interpersonal skill deficits; Chinese therapists judged white patients as demonstrating more severe pathology than did white therapists.¹ In light of these findings, it is not surprising that members of racial and ethnic minority groups experience disparities along the entire continuum of behavioral healthcare. Current policy shifts, including efforts to reduce insurance coverage for vulnerable groups and to target large numbers of undocumented immigrants for deportation, are likely to exacerbate these disparities by reducing opportunities to access care and increasing mistrust of institutions. We offer here some background showing the enormity of this issue and ways to address it.

Problems stemming from the power imbalance between majority group clinicians and minority group patients are exacerbated when the patient is poor, nonwhite, or does not speak English well. Research shows the powerful (typically the clinician) are prone to hasty judgments, often applying stereotypes to the others' behavior.² Because of time constraints and unconscious bias, clinicians may not spend sufficient time in "perspective taking" to understand the patient's circumstances and may see themselves as more objective than they are. As the Institute of Medicine Report on Unequal Treatment concluded, application of heuristics contributes to the core paradox of disparities in the clinical encounter: "*How could well-meaning and highly educated health professionals, working in their usual circumstances with diverse populations of patients, create a pattern of care that appears to be discriminatory?*"³

After conducting research for many years in community mental health clinics whose clients speak many different languages, we have gained a first-hand appreciation of the challenges clinicians confront in these settings. Meeting the needs of people from diverse backgrounds involves being able to provide culturally adapted evidence-based practice (EBPs) in a patient's primary language while ascertaining their goals for treatment, which likely differ

based on their social, cultural and geographical circumstances. However, few EBPs have been adapted for minority and immigrant groups. While there is growing evidence that EBPs in general are effective for members of racial/ethnic minority groups, almost no studies enroll enough diverse patients to conduct group-specific analyses that would provide clinical guidance regarding what treatments work, for what populations, and for what conditions.⁴ Testing and adaptation therefore often happens at the level of the individual clinical encounter but without sufficient guidance. Our experience shows that after adequate cultural and linguistic adaptations, physicians can tailor many evidence based treatments to broad cultural groups, like Latinos from different countries and socioeconomic conditions. Clinical supervision—itself a scarce commodity after formal training—rarely includes evidence-based ways to develop expertise in these cross-cultural encounters, leading to disparities in treatment quality. The end result is that it is virtually impossible for clinicians to be up-to-date on EBPs, receive the training necessary to competently manage cross-cultural encounters, and have the time necessary to practice behavioral healthcare that is effective and collaborative with diverse patients.

The challenges to receive adequate behavioral healthcare are also immense for patients. As patients or clinicians, we are aware of social status and our position in the social structure from each other and from language and interactions in the clinical visit. Yet, these social and cultural differences can be problematic. Patients who do not speak the same language as their clinicians experience worse outcomes⁵ and higher dropout rates. Some research suggests that perceived personal similarity between patients and clinicians is associated with a patient's higher ratings of trust and perceptions of healthcare quality.⁶ Yet, in one of our studies we found that more than a third of patients worked with clinicians who were dissimilar in cultural and socioeconomic background.⁷ Across the country, the percentage of Black and Latino psychiatrists, psychologists, and social workers and Asian psychologists and social workers is well below the representation of those groups in the population, including those seeking treatment.⁴ Gone and Trimble⁸ indicate that for American Indian and Alaska Native populations, limited clinical service availability and severe underrepresentation in research studies combine to make it unclear whether specific treatments are effective or should be promoted. Clinical and social outcomes of some evidence based interventions might be moderated by a patient's ethnicity/race or language⁹ but more importantly might vary by what is culturally accepted as adequate behaviors (like Native American smoking in rituals after smoking cessation interventions).¹⁰ This backdrop reflects the urgency of finding ways to reduce well-documented service disparities and to evaluate whether treatments have the same outcomes or preferences for these outcomes across diverse population subgroups.

What can we do about these persistent disturbing patterns within the limited resources available? The first step is to acknowledge that change needs to come from the system of care and from clinicians rather than from ethnic/racial minority or immigrant patients, that is to ensure that researchers and policymakers avoid reinforcing stereotypes of minority patients and viewing engagement and retention in services as a patient-level issue (i.e. thinking of patients themselves as being difficult to access or retain in services). Rather they should accept the system's responsibility for ensuring that treatments are accessible and acceptable to diverse patient groups. To identify issues in access, examine the ethnic/racial

distribution of who schedules a first appointment compared with the distribution in the communities being served. This may help identify disparities in treatment access and allow for identification of unmet need among specific ethnic/racial groups less likely to seek care. Examine engagement by looking at the distribution of who returns for a second visit compared to the first. Explore flexibility and adaptability in how care is offered (e.g., home visits, telehealth), where it is offered (e.g., in non-traditional settings, through medical vans, in community agencies), and by whom it is offered (e.g., community health workers, trained peer specialists). Work by Patel¹¹ and the Mental Health Gap Action Programme from the World Health Organization¹² on collecting and disseminating mental health resources provides useful evidence-based intervention tools for non-medical health workers worldwide. Giving a range of options to patients increases the likelihood that patient preferences can be accommodated in behavioral health treatment. In our experience, working with patient's perceived attitudinal and structural barriers during the first session will provide useful information that may improve engagement to services. Researchers like Grote and Miranda have demonstrated higher retention of socioeconomically disadvantaged populations by including engagement sessions regarding motivational interviewing and repeated outreach problems.¹³

Second, cultural brokers and specialized supervisors can help clinicians navigate cross-cultural encounters when no specific treatment adaptations are available and clinicians are unfamiliar with their patients' culture and background. Increased capacity building of non-medical front-line mental health workers may be an alternative in under-resourced settings.¹⁴ Training community case managers with similar backgrounds to patients has demonstrated effectiveness for treating depression among low-income minorities.¹⁵ Similarly, community engagement that involves empowering existing community agencies with specific training in mental health diagnoses and treatments have also shown reduction in help-seeking barriers and improvement in key outcomes for depression.¹⁶ Linguistic barriers may impede opportunities to obtain shared meaning of the major issues of the sessions, so cultural brokers and community health workers might help bridge the cultural and social gaps between patient and clinician.

Third, shared decision making, a type of communication in which both patients and providers hold expertise and work together to make a decision, may be a particularly helpful tool, because the patient becomes a co-producer of the treatment session. There is evidence that shared decision making increases patient satisfaction with services and yields greater perceived value of care. This is especially necessary when there is a discrepancy between evidence-based treatment and culturally-based patient preferences. In such instances, shared decision making between patient and provider might be the alternative to ensure that patient preferences are incorporated in treatment design.

Because a cultural match between clinician and patient will be rare, clinical supervision should occur to focus on the power differentials of the clinician-patient relationship. Recordings of clinical sessions can be reviewed to reflect on who initiates topics, how much verbal dialogue is allowed for the patient, and ways to encourage patients to become activated and ask more questions. Here we acknowledge the importance of motivational interviewing to establish an initial alliance with the patient, and also emphasize the

importance of the cultural formulation of how patients understand their problems and what matters most to them as potent factors in treatment. In order to preserve active listening, respect, and humility towards patients over time, clinicians may need coaching to allow patients opportunities to become experts in their illness and help them find viable ways to address the options that might work under their living circumstances. This may mean letting go of verbal and professional dominance in parts of the clinical encounter, of explicitly checking assumptions and meanings being made, and being more curious and open to explore the patient's solutions to their problems.

The behavioral health community has an opportunity to capitalize on the research base about how to improve cross-cultural clinical encounter, to hear the patient's voice, and create a partnership that shows patients they can be equal partners in problem solving, with the wisdom and trust to collaborate in finding solutions.

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