

Cultural Considerations in Health Research

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Objectives

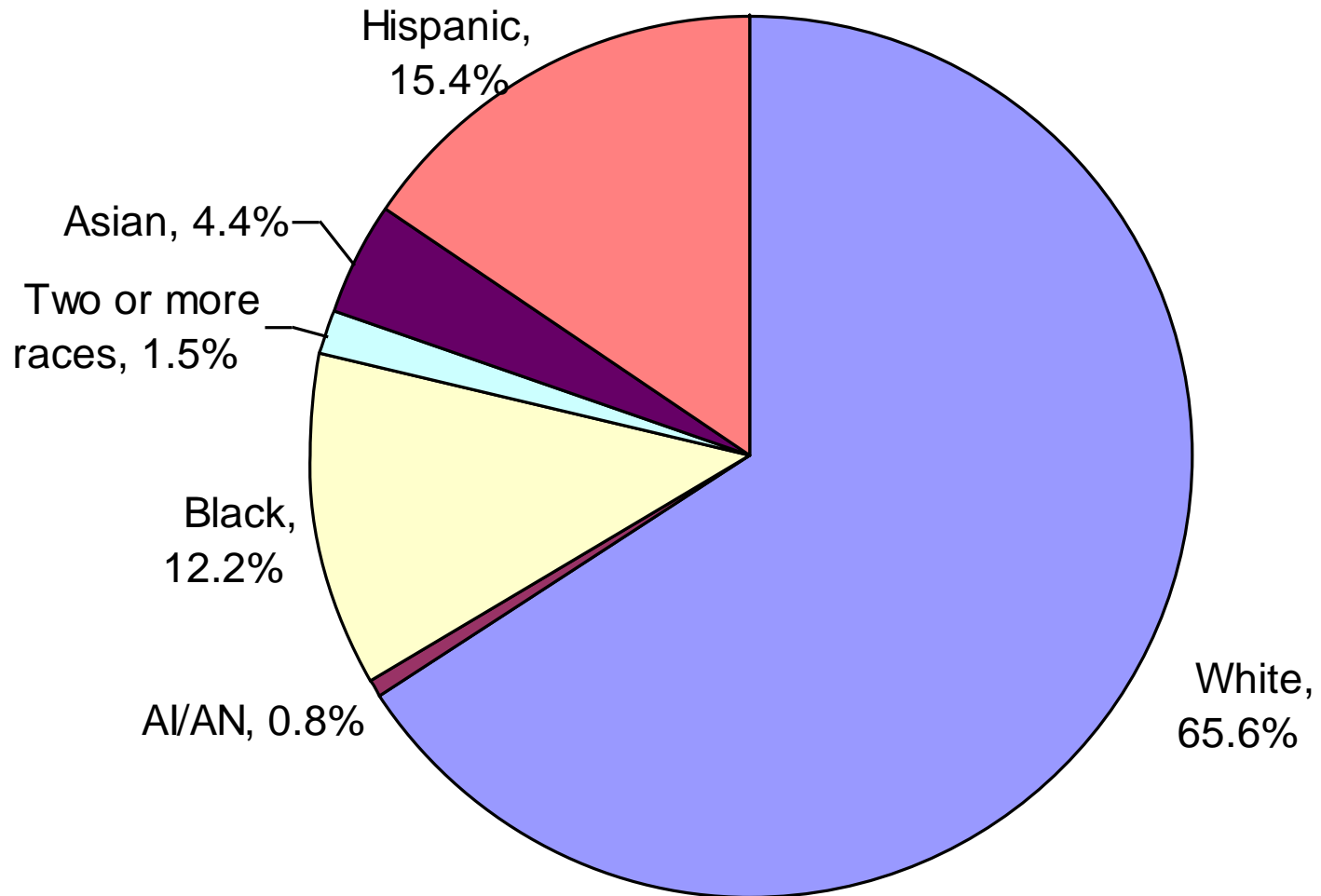
- The goals of this presentation are to: 1) understand sociocultural factors that facilitate and/or hinder participation in medical research; 2) understand barriers to cross cultural communication; and 3) learn strategies for effective cross cultural communication



IOM Report

- The IOM (2003) reported that minorities were less likely to receive the health care they needed even after taking into account health insurance coverage and other economic and health factors.
- Higher breast cancer mortality among African American women compared to white women, increased risk for diabetes among African Americans, Hispanics and Native Americans, lower use of preventative screening among rural populations, disproportionate rate of prostate cancer among African American men

US Population: Race/Ethnicity




Source: US Census Bureau 2008

Our Multicultural Nation

U.S. White Population Will Be Minority by 2042!

- “Minorities” will make up 54 percent of the U.S. population in 2050, compared with 34 percent of the population in 2008.
- More than half of all U.S. children are expected to be from minority ethnic groups by 2023.
- Source: Bloomberg.com, *August 14, 2008*





The growth of racial, ethnic and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care system.

Increasing diversity demands more cultural understanding



Disparities in Mental Health Care

The Surgeon's General Report in 2001 indicated that minorities:

- Are less likely to receive services
- Receive poorer quality of care
- Are underrepresented in mental health research

Racial and Ethnic mental health disparities: Key Studies

- Minorities in the US are more likely than whites to delay or fail to seek mental health treatment (Sussman, Robins, and Earls 1987; Kessler et al. 1996; Zhang, Snowden, and Sue 1998).
- After entering care, minority patients are less likely than whites to receive the best available treatments for depression and anxiety (Wang, Berglund, and Kessler 2000; Young et al. 2001).
- African Americans are more likely than whites to terminate treatment prematurely (Sue, Zane, and Young 1994).
- *from “Mental Health: A Report of the Surgeon General” (DHHS 1999) and its supplement, “Mental Health, Culture, Race and Ethnicity” (DHHS 2001),



Statement of the Problem

- Underrepresentation of minorities in health related research
- The 1993 National Institutes of Health (NIH) Revitalization Act mandates minority inclusion in trials
- Recruiting subjects for participation in medical research is challenging.
- What sociocultural factors contribute to low participation in medical research?



Sociocultural factors that facilitate and/or hinder participation in medical research

- ❑ Mistrust of the scientific and medical community particularly among African American (Tuskegee Syphilis Study)
- ❑ Informed Consent (belief that it protects hospitals and doctors from legal responsibility)
- ❑ Failure to see need (too much risk, even if something good AA would not benefit because of racial and poverty discrimination)
- ❑ Cultural shaped conceptions of the disease (fears of worsening health, dementia seen as part of aging process and not disease, research seen as harmful because of excessive worry, stigma)
- ❑ Lack of awareness of the available study
- ❑ Failure to meet eligibility criteria
- ❑ Sampling Approach (probability vs. nonprobability)
- ❑ Study Design (intervention vs. observational), flexibility in intervention protocols



Perceived Benefits

- State of the Art Medical Care
- Help extended family and broader society



What facilitates participation?

- ❑ Honest and respectful communication
- ❑ Complete information about risks and benefits of research
- ❑ Sufficient time to consider options
- ❑ Reducing participant burden
- ❑ Early education and awareness about research
- ❑ Purpose of the study and opportunities to participate
- ❑ Consent forms: not risk and benefit but trust
- ❑ Multiple referral sources (brochures, flyers, community postings)
- ❑ Improving staff sensitivity
- ❑ Cultural adaptations (mixed results)
- ❑ Personal belief of the about disease



Barriers to cross cultural communication

The needs or expectations for both parties in the exchange are often either not understood or not mutually shared.



What is culture?

Culture influences how people express their feelings as well as that feelings are appropriate to express in a given situation

Culture consists of the beliefs, behaviors, objects, and other characteristics common to the members of a particular group or society. Through culture, people and groups define themselves, conform to society's shared values, and contribute to society. Thus, culture includes many societal aspects: language, customs, values, norms, mores, rules, tools, technologies, products, organizations, and institutions. This latter term institution refers to clusters of rules and cultural meanings associated with specific social activities. Common institutions are the family, education, religion, work, and health care.



Culture and Language influences:

- ❑ how health care information is received (doctor-patient interaction)
- ❑ what is considered to be a health problem
- ❑ how symptoms and concerns about the problem are expressed
- ❑ who should provide treatment for the problem (help seeking behaviors)
- ❑ what type of treatment should be given (medication vs. psychosocial therapy)
- ❑ Communication (verbal and non-verbal)
- ❑ Help-seeking behaviors
- ❑ How people perceive and cope with mental illness (spirituality)
- ❑ Stigma and shame associated with mental illness



Who is included in a cultural group?

A subgroup from a major racial/ethnic group: African Americans, Hispanic, Asian American/Pacific Islander, American Indian/Alaskan Native or from a recent immigrant or refugee population. Subgroups can also be identified by a specific language or locales of origin. The agency can identify a subgroup that requires special attention, e.g., gay and lesbian communities, people with hearing impairments, rural and “mountain folk,” migratory workers.



Unique Cultural Being

- Each individual is culturally unique
 - Product of past experiences
 - Cultural values & beliefs
 - Cultural norms
 - Cultural expressions
 - Cultural behaviors
 - Cultural perceptions

Reference: Fatima Sharif, CLAS Act Coordinator: Office of Minority Health & Public Health Policy: Advancing Health Equity for All Virginians.

Cultural Competence. . .

...Cultural Competence has gained acceptance from health care policymakers, providers, insurers, and educators as a strategy to

impro
dispa

Cultural Competence

*a supplementary component
to the Educator Concentration Grant*



Funded by Health Resources and Services Administration (HRSA) Division of Nursing



Working definition by the Office of Minority Health,
US Dept. of Health and Human Services:

*“Culture is
the thoughts, communications,
actions, customs, beliefs,
values, and institutions of
racial, ethnic, religious, or
social groups.”*



Key Points about Culture:

- ❑ Culture is NOT homogenous or static
- ❑ Culture is NOT a single variable, but comprises of multiple variables

Why is it so important?

1. As the United States becomes more diverse, clinicians will increasingly see patients with a broad range of perspectives regarding health, often influenced by their social or cultural backgrounds.
2. Research has shown that provider-patient communication is linked to patient satisfaction, adherence to medical instructions, and health outcomes. Poorer health outcomes may result when sociocultural differences between patients and providers are not reconciled in the clinical encounter. **These barriers do not apply only to minority groups but may simply be more pronounced in these cases.**

□ Betancourt et al.



Barriers to Cross-Cultural Communication

- ❑ Assumed similarity
- ❑ Non-verbal communication
- ❑ Language itself
- ❑ Cultural perceptions
- ❑ Preconceptions
- ❑ Stereotypes
- ❑ Fear of government and police
- ❑ Fear of deportation
- ❑ Fear of bringing shame to the extended family/clan/community



Culturally and Linguistically Appropriate Services (CLAS) Standards:

- ❑ guidelines established by the federal Health and Human Services Department, Office of Minority Health
- ❑ mandated for all health care organizations receiving federal funds.



US Dept of Health and Human Services, HRSA grants:

- All Health Resources and Services Administration (HRSA) grant applications require addressing cultural competence

Ideally, Cultural Competency in Psychiatry would...

- Enable patients and doctors to come together and communicate effectively
- Lead to health care services that are respectful and responsive to culture.
- Improve patient satisfaction and patient outcomes.



Communicating with Culturally Diverse Populations

- Effective communication depends on how all parties in the interaction behave and how the behavior is perceived by the viewer, listener, or speech partner.
- This takes place when participants in the interaction have developed not only respect for diverse interaction styles, but when they have developed multiple interaction skills.



Multiple Interaction Skills

- ❑ Multiple speech styles
- ❑ Good talker and good listeners (i.e., putting yourself in the other person's shoes)
- ❑ People can speak directly and indirectly
- ❑ Involves communication through verbal speech and nonverbal speech.
- ❑ Paralinguistic elements of speech as pitch, stress, intonation and speed of speech
- ❑ Keep in mind that concepts may be interpreted differently by diverse groups



Managing Cross-Cultural Differences

An Example of Different Meanings of the Same Gesture

UK & USA = O.K.

JAPAN = MONEY



RUSSIA = ZERO

BRAZIL = INSULT

Factors to Consider in Developing Diverse Speech Styles

- In cross cultural interactions: speech reciprocity, conversation structure and turning taking are particularly important:
- **Speech reciprocity:** To what extent do different speech partners initiate the conversation? Who initiates subsequent questions or topic changes? Does each speaker pause or talk about the same time

Factors to Consider in Developing Diverse Speech Styles

Conversation Structure:

- Do people present their main point first, followed by elaboration and supporting information, or do they present a general picture first, saving the main point until sufficient background information has been given?
- Developing skills of directness and indirectness as appropriate to different cultural situations, decreases negative judgments about interactions with others.

Factors to consider in cross cultural communication

Examples that can be viewed as shameful to some cultures...

- ❑ Any reference that suggests that the person speaks poor English
- ❑ Treatment of an elder without the proper degree of respect
- ❑ Any expression of displeasure or irritation at the patient's health beliefs or behavior



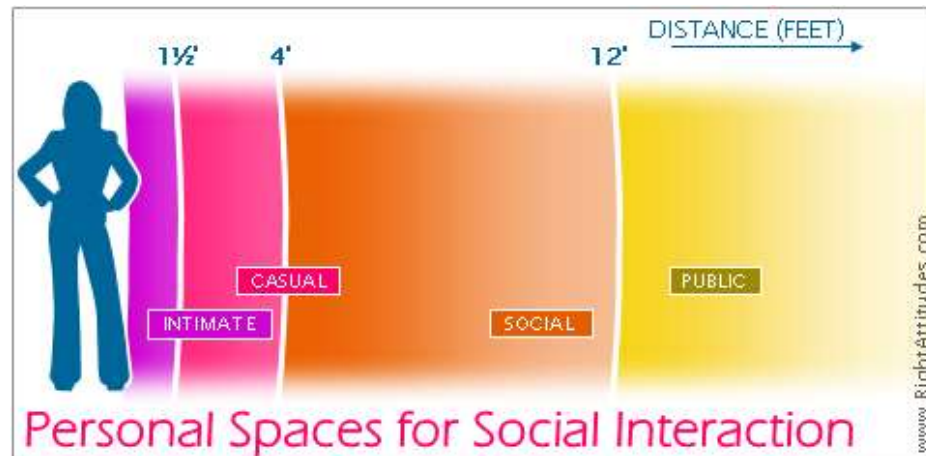
Other considerations...

- ❑ Addressing the patients chief complaints and reducing symptoms (within the context of socioeconomic and cultural scripts, e.g., mal de ojo). In Latin cultures, children are most vulnerable to the evil eye.
- ❑ Framing family challenges in a supportive and nonjudgmental manner is more effective than addressing them immediately and directly, nonverbal cues
- ❑ Understanding the patient's narratives (e.g., trauma, poverty and discrimination);
- ❑ Fostering empowerment (e.g., incorporating sociohistorical context)

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- Issues around space, e.g., Latin American and Arabic patient may feel that he needs to get closer to the physician
 - The use of eye contact in communication also varies among cultural groups
 - Arabs, Latino Americans and Southern Europeans focused their gaze on the eyes or face of the partner whereas, Asian, Indians and Pakistanis, Northern Europeans tended to avoid direct gazing.
 - Differences in the belief of the causes of the health-related problem

Considerations When Interacting with People of Other Cultures

- Personal Space: A person from one subculture might touch or move closer to another as a friendly gesture, whereas someone from a different culture might consider such behavior invasive.



Source: *Transcultural Nursing: Assessment and Intervention* (Giger and Davidhizar, 1999). <http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/sectiontwo.asp>

Considerations When Interacting with People of Other Cultures: Personal Space

Nation of Origin	Desired Space
Asian	Non-contact people
African	Close personal space
European	Non-contact people;
American Indian	Distant
Hispanic	Space important; no boundaries
African Americans	Tactile relationships; close
Caucasian Americans	Non-contact

Perspectives of Latino Clients – The Centrality of Language

- *“The language is the most important thing. Nothing replaces the language.”*
- *“They mistreated patients because there was no one that spoke Spanish.”*
- *“The doctor told my interpreter that I need to learn English.”*
- *“I was in a treatment where I was not able to communicate well and that affected the treatment.”*

Perspectives of Latino Clients – Understanding Cultural Idioms

- Not only do clinicians need to understand the language in a general sense, they need to understand the specific meanings of cultural idioms that people use to describe their emotional problems
- *“I told my doctor that my nerves were bothering me a lot and he didn’t understand.”*

Perspectives of Latino Clients – Being Able to Share Emotions

- Latinos felt like they and clinicians needed to be able to share their emotions with each other; they needed a personal connection.
- *“Therapists can cope if you are mentally imbalanced, but can’t cope if you pour your heart out. The best way to deal with emotion is with emotion.”*

Perspectives of Latino Clients – Collectivism is Not Dependence

- Extended family is central in Latino culture. There is a tendency for intensive involvement with family to be viewed as dependence and to judge it negatively.
- *“Therapists need to understand the value systems of the culture because what may seem to be an unhealthy dependence, you know, may be just a natural value like, a culture that prizes collectivism. We belong all to the bigger group as opposed to just being very independent.”*

Perspectives of African American Clients

Treat Me as an Individual and Understand My Context

- African American clients felt that European American clinicians could not fully understand the lived realities of their lives
- *“My therapist can identify with me as a woman, but not as a Black woman. My brothers could be shot on the street at any time. I know she would glaze over it. But if I had an African American therapist, they would appreciate it.”*



Findings from Qualitative Research on American Indians, Vietnamese, Hmong and African Americans (Fu et. al. 2007)

- **Counseling**
- – Women generally had more positive reactions to counseling than men.
- – Among African Americans and American Indians preferences tended to be for group over individual counseling.
- – Greater levels of acculturation appeared to be associated with more positive attitudes toward counseling among Vietnamese participants. Vietnamese men preferred individual over group counseling.

- **Views of doctors**

- – Few sought out doctors or perceived doctors to be a resource for help to quit smoking.
- – Doctors' expertise was generally seen as restricted to knowledge about medication.

- ***African Americans and American Indians***

- – Mixed views about using doctors for help with cessation. Men especially had very negative opinions of doctors and the medical profession.
- – Explanations for not seeing doctors tended to focus on negative qualities of particular doctors or of the medical establishment. Doctors were viewed as impersonal, blaming and confrontational.
- – Some believed doctors could be effective if they used a personal and nonconfrontational approach.



□ *Hmong and Vietnamese*

- – Positive attitudes toward doctors, who were seen as a trusted source of expertise.
- – There was little awareness, especially among the Hmong, that doctors could provide cessation services.
- – The cultural value of mental control and self-determination, especially among the Vietnamese, was seen as the most important determinant of quitting smoking.

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- **Attitudes and beliefs about medications**
 - – Except for Hmong-speaking men, most were aware of over-the-counter medications (e.g., nicotine patch and gum); less awareness with prescription medications.
 - – Most had low levels of knowledge about the functional benefits of pharmacotherapy. Participants did not understand that pharmacotherapy could be used to help them with cravings and withdrawal symptoms.
 - – Concerns about side effects (e.g., overestimation of risks of side effects compared to risks of smoking).
 - *“Why would you take something to stop smoking and then get three or four different side effects? When you only got one with smoking. Give up one and get three or four side effects.”—African American male smoker*
 - – Skepticism about the effectiveness of medications. Participants expressed skepticism about the benefits and effectiveness of medication, especially African Americans and American Indians.
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- **The idea of taking pills met with more resistance than other modalities.**
 - *“...I would be kind of hesitant about the patch because now it's like they*
 - *have a patch for everything... There's a patch to stop smoking, a patch to*
 - *not get pregnant, it's like you know, and it doesn't seem believable.”—*
 - *African American female former smoker*
 - – Cost of medications and lack of accessibility perceived as major barriers to their use. Cost emerged as a significant obstacle to pharmacotherapy, with many participants unaware that insurance or other programs were available to pay for treatment.
 - *“All those products, right, cost too much. To the average smoker you*
 - *rather pay \$4 for a pack of cigarettes than \$25, \$95 for Nicoderm or \$20*
 - *for Nicorette and they say, ‘what's the use?’.”—African American male*
 - *smoker*



- **Receptivity toward medications**

- – “Word of mouth” was a powerful influence on decisions to use or not use pharmacotherapy.

- – The use of “personal testimonies” was suggested by participants as a way to increase acceptance of pharmacotherapy.



□ **Concerns about side effects**

- Participants expressed concern about smoking adversely affecting their health but appeared to underestimate the risks associated with smoking relative to the risks associated with medication. Participants believed that the side effects of medications would likely be worse than the effects of smoking. Perceived side effects included such severe conditions as “bleeding liver”, blood clots, stroke, heart attacks, hallucinations, depression as well as headaches, stomach cramping, and drowsiness.
- Further, participants recounted stories of friends and family members who experienced side effects while taking stop-smoking medications. Related to this were a number of accounts of people smoking while using medication, and getting sick as a result.

General Intervention Guidelines

- **Use open-ended questions to gather more data.**
 - Open-ended questions cannot be answered with a simple “yes” or “no.”
 - Avoid complex sentences
- **Use audience-centered language.**
 - When you speak, focus on your audience’s values, needs, and preferences. Avoid talking from your perspective.
- **Employ reflective listening.**
 - Repeating or paraphrasing what you heard allows the person you are talking with to clarify or add more information if necessary. This technique also forces you to really think about what was said.
 - Speak slowly
- **Be assertive, not aggressive.**
 - Make your point strongly, without attacking the other person of a different opinion.

General Intervention Guidelines

□ **Be flexible**

- Alter your communication strategies as the situation necessitates.

□ **Recognize and respect differences**

- Do not assume the majority's way is the only way.
- Do assume that there is more to a person than meets the eye.

□ **Be honest**

- Acknowledge any discomfort, hesitation or concern you may have.



General Intervention Guidelines

- **Learn from cultural informants...**
 - Values, family norms, traditions, community politics, etc.
- **Involve bilingual and bicultural staff.**
- **Establish rapport. Gain acceptance.**

Use interpreters/translators with caution

- ❑ Translators may help as well as hinder the communication process. In some cases the patient might withhold embarrassing information from family member. Try to seek a trained, highly-skilled translator.
- ❑ A review of meeting between doctors and non-English speaking patients revealed that language interpreters make many mistakes, more than half of which could have a negative impact on patient's health (McCook 2003)
- ❑ An analysis of 13 doctor-patient visits that included a Spanish-English interpreter (e.g., “ad hoc” interpreters such untrained family members, friends or people at the hospital) found interpreters made an average of 31 mistakes per visit, 19 of which could have negative consequences for the patient (McCook 2003)

Self Reflection – a place to start:

Clinicians should start by recognizing their own culture and how the culture of medicine and psychiatry might lead to unconscious:

- Biases
- Inappropriate and excessive use of medical or psychopharmacological interventions
- Stereotyping

“First do no harm by stereotyping”

What really matters?

A good place to start.


- What we want to understand is **WHAT REALLY MATTERS** to the patient.
- Ask: What is really at stake for the patients, their families, and at times for themselves or communities
- Routinely ask patients (and where appropriate family members) what matters most to them in the experience of illness and treatment.
- This information can then be used in thinking through treatment decision and negotiating with

Wise Words



“Main thrust (of culturally informed care) is to focus on the patient as an individual, not a stereotype; as a human being facing danger and uncertainty, not merely a case; as an opportunity for the doctor to engage in an essential moral task, not an issue in cost-accounting”.

- Arthur Kleinman

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- However, as providers and researchers, we must be careful not to oversimplify things, or to stereotype.
 - While in health care, culture is often made synonymous to race/ethnicity/language- we should remember that culture can encompass much more.
 - A good place to start is by reflecting on our biases and being aware of our own culture and how it might influence our clinical decisions or responses.

Take Home Message

- *“To be culturally competent doesn’t mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural differences and are eager to learn, and willing to accept, that there are many ways of viewing the world.”*
- ~ **Okokon O. Udo** ~ Ph.D., CPCC founder and president of Distinctive Leader Options, Inc. former Executive Director of the Center for Cross Cultural Health.
- http://www.newahec.org/Cultural_Competency.html

References:

- ❑ Alegria et al. Disparity in Depression Treatment Among Racial and Ethnic Minority Populations in the United States. *Psychiatric Services*. Nov 2008, vol 59 no 11.
- ❑ Alegria M., Canino, G., Shrout, P., Woo, M. Duan, N., Vila, D., Torres, M., Chen, C., and Meng, X. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry*, 165 (3), 359-69.
- ❑ Betancourt, J et al. Cultural Competence and Health Care Disparities: Key Perspectives and Trends. *Health Affairs*, 24 ,no 2 (2005): 499-505 <http://content.healthaffairs.org/cgi/content/full/24/2/49>
- ❑ Kleinman, Eisenberg, Good. Culture, Illness and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research *Focus* 4:140-149, Winter 2006 **Reprinted with permission from the *Annals of Internal Medicine* 1978; 88:251–258**
- ❑ http://www.newahec.org/Cultural_Competency.html
- ❑ P. B. Pedersen (1988). A handbook of developing multicultural awareness. Alexandria, Va: American Association for Counseling and Development
- ❑ OMNA Minority office Fact Sheet Draft 2009



Thank you!

Questions?