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## Cultural Awareness in Mental Healthcare

Presented by [Mary Beth Dahl; Cynthia Fashaw] (45-minute Webinar) [07-14-2015]

**Chelsey:** Today's webinar is the first in a series titled: Reducing Racial Disparities in the Treatment of Depression. Our topic for today is Understanding Cultural Perceptions of Mental Health Issues Can Help Practitioners, More Effectively Treat Patients with Depression. We have two subject matter experts speaking on today's webinar, Mary Beth Dahl; Program Manager at Stratis Health, speaking on Cultural Basics and Care and Cynthia Fashaw, Director of Children's programs and Multi-Cultural Outreach for the National Alliance on Mental Illness, a.k.a. NAMI.

My name is Chelsey and I am a Quality Improvement Specialist with UCare. I will be moderating today's webinar. On behalf of the Minnesota Health Plan Collaborative, working to reduce disparities and improve anti-depressant medication management. We will have time for questions following the presentation and you will receive a web link in an email to submit any questions that you have, due to technical difficulties in the original recording of this webinar. With that, I want to welcome Mary Beth to begin her presentation on Cultural Basics.

**Mary Beth:** Thank you Chelsey. As Chelsey said, my name is Mary Beth Dahl. I'm a Program Manager at Stratis Health. I oversee the Culture Care Connection website, as well as over the years I've worked with many clinics, public health agencies and other healthcare organizations that have experienced cultural barriers and challenges.

Before I start I think it's important to note that not all patients or clients from diverse cultures will conform to some of these common culture specific behaviors, beliefs and actions. We all need to get to know our patients and clients on an individual level. This is only a starting place as everyone has their own unique culture and behaviors. I love this quote '*Seek first to understand then to be understood.*' I think we first need to look at ourselves and understand ourselves and where we come from before we can truly understand other people.

Today we're going to look at cultural influences in our life. As culture plays a role in everything we do, both at work and at play. We all know that language poses one of the biggest cultural barriers in healthcare, but we will also explore difference, not only in the languages that we speak but how we speak it, as well as those sometimes subtle and not so subtle verbal cues.

Lastly, I hope I can share with you some strategies, tools and resources to help you become more culturally responsive and confident.

Let's try to uncover the influence of culture. **What exactly is culture?** This definition is from the U.S. Department of Health and Human Services. They say culture is the integrated pattern of thoughts, communications, actions, customs, beliefs, values and institutions associated wholly or partially with racial, ethnic or linguistic groups, as well as with religious, spiritual, biological, geographical or sociological characteristics. Culture is dynamic in nature and individuals may identify with multiple cultures over the course of their lifetime.

Can you think of anything that was missed in this definition? One thing that pops out at me is there is no mention of socioeconomic.

To me, poverty and wealth for that matter, play a huge role in culture and is woven into many cultures and populations. The one thing I really did like is that it says that culture is dynamic and ever-changing in nature, and individuals may identify with multiple cultures

over the course of their lifetime. This is so true. Think of yourself at age 16, 32, 48, have your thoughts, patterns, communication styles and spiritual awareness changed over time? Usually the answer is a resounding yes. I know it's true for me. As you evolve as a person so does your culture.

This is from Edward T. Hall at Cultural Iceberg Model. Edward T Hall was an anthropologist and cross cultural researcher. He uses an iceberg as an analogy for culture. The external or conscious part of culture is what we can see and is the tip of the iceberg. It includes: behaviors and some beliefs. The internal or subconscious part of culture is below the surface and many times includes: beliefs, values and thought patterns that directly influence our behavior. Hall suggests that the only way to learn the internal culture of others is to actively purchase a place in their culture. What this model teaches us is that we can't judge another's cultures based on what we see when we first encounter it, we must take the time to get to know individuals from that culture and interact with them. Only by doing so can we uncover the values and beliefs that underlie the behavior. This is especially helpful in understanding a patients or clients compliance with a specific therapy.

There are many factors that influence culture. Such as how much education we have, if you're from a rural or urban community, how old you are and how long you've been in the United States. These are just a few. Now I want you to think about someone that looks like you, talks like you, but was raised by Missionary parents in East Africa. Would they have the same cultural views as someone who grew up in the United States? No. They'd have a very different view, but how would you know that without getting to know them? We need to talk with people and truly understand their cultural beliefs.

#### Sense of self and space–

**How do you greet people you don't know?** In a dominant culture, usually by a handshake. In some cultures it's a bow and in others it may be a kiss on the cheek. **What is a comfortable talking distance?** It's about an arm's length in Minnesota, but in some countries and even in some southern states it's much closer. Take notice of what you do when someone gets too close when you're talking to them. You automatically take a step back and they usually take a step forward. You're both trying to maintain a talking distance that is comfortable to you.

In many countries compact living is the norm. There's frequent and close contact with others. Value may be placed on sharing with others and often that means sharing a room or house with extended family or friends. A person who lives alone may be pitied. Very different from our dominant culture in the U.S. For those of you who have ever worked on phones or have answered a phone with a salesman, have you ever answered the phone and they start talking, not letting you even get a word in edgewise? That's phone space. You can even feel it when you're on the phone.

#### Cultural influence as it relates to food–

**What types of food do you eat?** If you're old like me you follow the food pyramid. Do your patients eat the same things as you? Ask someone about any differences and the next time you're in the store, try something new that may have cultural influences. Also, some cultures have food restrictions such as fasting during different times of the year. What drives this? How is this going to affect your patients with diabetes or other illnesses? Don't be afraid to ask questions.

For many cultures a 9:00 o'clock a.m. appointment means sometime in the morning. They aren't trying to upset the system they just have a more elastic version of time. If you are very time conscious it may anger you when someone is more flexible at times. This can cause a great deal of turmoil in the clinic setting where appointments run in 15 minute increments. If one person is late that throws everything off. You may want to think about alleviating this with walk-in clinics and hours. In many cultures time is measured by natural events, such as sunrise, the first snow and the seasons, clocks aren't even used. Emphasis is placed on

present living not the future. Having patience, showing respect and caring for others is more important than being on time.

**Who do you consider family?** Your immediate family, extended family. How about your neighbors and community? In many cultures the emphasis is on we, rather than I. Self-promotion is frowned upon. They may look to extended family and community elders for guidance and direction. Decisions are shaped by the preferences of others, making any medical decisions a little more complex. Being loyal to the group and avoiding conflict is valued, especially with that extended family. I think you can see how this may conflict with the dominant culture in Minnesota and the U.S., where decisions are made independently and looking out for number one is a common mantra.

Verbal and non-verbal communication– I want you to ask yourself these questions.

- What does someone's tone tell you?
- Are you a direct or indirect communicator?
- Where does non-verbal communication fit in?

Even without words we convey messages to each other.

In the next few minutes we're going to explore language, both written and oral, as well as the use of voice and styles of speech. We all know how language barriers can negatively affect the clinical encounter. To counteract this, always use a trained interpreter. Never use family members or friends as interpreters. Remember that we have many oral cultures in Minnesota, meaning they may not read or write their own language. One common oral culture in Minnesota is the Hmong.

The use of voice is probably one of the most difficult forms of communication to change, as we rarely hear how we sound to others. If you speak too fast you may seem uninterested. Too loud as many foreigners see Americans and you may be perceived as domineering. Too soft and you may be seen as not having a lot of confidence. Expectations on the use of voice vary between and within cultures. For males and females, young and old, the best advice on the use of your voice is to search non-verbal cues to determine how your voice is affecting your patients or clients.

People vary greatly in the length of time between comment and response, the speed of their speech and the willingness to interrupt. Some advice may be to tolerate gaps between questions and answers and patients silence can be seen as a sign of disrespect in some cultures and a lot of people have issue if there's too much silence and they want to fill it. Listen to the volume and speed of your patients or clients speech, as well as the content. Modify your own speed to match theirs to make them feel more comfortable. Rapid exchanges and interruptions are a part of some conversational styles. Usually no offense is intended when a patient or client interrupts you. Become aware of your own pattern of interruptions, especially if the patient or client is older than you.

Non-verbal communications... **what does making eye contact in American and Western cultures mean?** Even some interview recommendations include the importance of making good eye contact. This usually means honest and attentive in American and Western cultures. It's good to look people in the eye, but it may be disrespectful and rude in Latino, Asian, Middle Eastern and Native American cultures. In some Middle Eastern cultures, eye contact between men and women means sexual interest.

Also, in many cultures men and women do not touch. In some, the left hand is used for hygiene purposes and you should not touch another person or transfer objects with that hand. In Muslim cultures, touch between genders may be seen as inappropriate. In Western cultures, patting a child's head is considered friendly, but this may be considered inappropriate in many Asian cultures where the head is believed to be a sacred part of the body. Others may also avoid admiring babies as it may be overheard by spirits that may cause harm to the child.

We touched a little on the use of space earlier and if you look at the pictures you can see there's a big difference in the space that's provided. Just remember that personal space is just that, personal and we each have our own comfort zones. Latin Americans often have a closer personal space than Americans and the same is true for southerners compared to us northerners. The next time someone enters your personal space, challenge yourself to acknowledge what's taking place and don't take that step backwards.

Looking at the next slide you don't know what the people are saying, but you can tell it's probably not a pleasant conversation. Sociologists say that 80% of communication is non-verbal and I've heard even upwards of 90%. The meaning of body language varies by culture, class, gender and age. If a patient or client moves closer to you or touches you, you usually may do the same. However, stay sensitive to those who do not feel comfortable and ask permission to touch them, if touch is needed in a medical exam, for example.

Gestures can mean very different things to different people. Be very conservative in your own use of gestures and body language. Ask if unsure about unknown gestures or reactions. The thumbs up, we all think that's a positive, where in many cultures it's like flipping someone off. Also, the way that pain, fear and other emotions are expressed is closely tied to a person's culture and personal background, one size does not fit all.

### **What is the most important thing?**

This is from the aligning forces for quality report from Minnesota Listening Groups. These are the things that the groups felt were the most important that providers provide and that is:

- the development of trust,
- listening,
- respect,
- seeking to understand other people's culture,
- spending enough time with them and
- building a long-term relationship.

I'd have to say it is how most of us want to be treated by providers.

Trust  
Respect  
Time

### **What can we do?**

If there is some prominent or emergent cultures in your area, familiarize yourself with the traditions and customs so that you have a foundation for starting that conversation with them. Recognize and act on non-verbal cues. If a culture doesn't like direct eye contact, maybe you sit next to them instead of across from them. Ease into someone's personal space if you're unsure and be aware that male/female contact is regulated in many cultures and plan accordingly. It may be if you're in an OBGYN office having female OBGYN's with certain cultures. I know there was an issue with an on-call OBGYN, who had a cultural difference where they wanted a female OBGYN and they had her but when she went into labor it was a male partner and there was a lot of issues with that, so think the process through.

Always ask a parent before touching a child, so if you're going to give a shot, teach how to use a bike helmet or put them in car seat, always ask permission. Use gestures conservatively and recognize that physical presentation is not an indicator of economic situations. For many people in many cultures they want to show their respect by dressing up, so they may dress nicely to go to the doctor's office and staff may think they have a lot of money so they may not offer different things they may need, but that doesn't always mean they have money, it's just a way of showing respect.

Become aware of your own use of voice when you speak to others. Now you're wondering, how do I say that? Here are some suggestions: "I understand and respect your cultural belief, please tell me about... (whatever it is you're talking about)..." and then ask, "What do you usually eat? Are there times during the year when you change your eating in celebration of religious and other holidays? Can you share a little about that? To better go over these materials is it okay if I sit next to you?" Do your clients or patients know the basics? Prepare a handout that explains office hours, how to contact the office if it's closed, how to make an appointment and what to do in an emergency.

You may want to read this over with them instead of just handing it to them, because they may not be able to read it. Have instructions available in common languages spoken by your client or patient population. Make sure the instructions use living room language and not big medical terms. Explain the different roles of people in your agency or clinic. Someone not from the U.S. may not know what the role of the doctor is or what the role of the nurse is. They may not know those nuances that we take for granted.

Remember, family members and friends as interpreters always edit messages heavily. They may change the power dynamics of the family, so if you have a culture where the elders are greatly respected and you have a child or family member interpreting for them, that changes family dynamic. They add their own opinions. They may answer for the client. It slows down the development of the relationship, there are confidentiality issues and many are rarely trained for accuracy completeness and impartiality.

Recognize that patients and clients from diverse backgrounds may have different communication needs. Be patient. Providing services across a language and/or cultural barrier takes time. The time spent up front will be paid back by good rapport and clear communication.

This is a good resource (slide on ICE Toolkit). It has a lot of different pieces to it. If you get a chance click on the link and check it out. Also, other resources, there's a blueprint for advancing and sustaining class policy and practice that are culturally and linguistically appropriate services. Stratis Health has a website The Culture Care Connection. The Office of Minority Health has online curriculum with free CEUs for nurses and CMEs for doctors, and the exchange is a library of translation materials. If you want to check it out you can use it. It's a member library but you can use the name Stratis, password health just this once if you want to check it out. Also, the Minnesota Health Literacy Partner website is a great resource.

Thank you so much for your time. My contact information is there if you have any questions. I'm happy to answer them.

**Chelsey:** Thank you Mary Beth. I'm going to shift now to Cynthia to begin her presentation... Lessons from Those Who Live It.

**Cynthia:** Thank you. I want to talk a little about the cultural perspective of mental illness help seeking. Mental illness manifests and is perceived differently throughout cultural communities. For example, you might see a patient who presents with a mental illness and it manifests itself in terms of somatic symptoms or, you may see someone who has fear that what they're experiencing is due to the fact that they've angered deceased relatives. Or, you may see someone who discusses having a learning disability.

Likewise, help seeking and expectation of the type of health and expected outcomes have no single cultural perspective. So direct experience with mental health systems is limited for many in cultural communities. Many are reluctant to access the system due to fears of being over medicated, being prescribed medications that might make symptoms worse or becoming medication dependent. While others express a desire to see someone concerning mental health symptoms, but lack knowledge and information about what they need to do.

There are a lot of reasons why people do not access mental health care. A lot of people don't know anyone who has access to mental health care and much about how one accesses mental health pre-assumes a certain amount of education and knowledge, which

people may not have. Recently, between September 2014 and February 2015, NAMI Minnesota, undertook to conduct focus groups among cultural communities statewide. The focus groups were conducted with:

- African American
- Native Americans
- Chicano/Latino
- Russian
- GLBT community

The focus groups were done with transition age youths, young adults, elders, and family members of children who live with a mental illness, chronic illness or both. In the focus groups participants were asked 18 questions, 9 of which were two-part questions. The questions sought information from them in the areas of health promotion, medical and mental healthcare experience, care coordination and management and care transition. Questions specifically addressed participant's experiences with physical, mental and transitional healthcare, the barriers they encountered receiving care; cultural, spiritual, physical health needs and practices, and the extent to which these practices were incorporated in their care experience.

It also asked preferences for receiving health information, how they wanted to get it and what worked best. And, perceptions of an opinion on how their healthcare delivery and health could be improved. We actually found some overriding things from most of the cultural groups and then some that were more individual to the cultural group and age.

We're going to talk now about some of the overriding things, the factors that influenced health seeking and care plans. We found that trust and relationship were two very prominent things. In terms of relationship, a provider that was willing to disclose what they would do in a situation or what they would do for a family member that was in the same situation. Provider approach was huge, I'll explain that soon. The offering of medication was also a theme that was common to the groups.

Trust– Provider trust and relationship were the prevalent things that emerged in all groups. Participant's identified having a relationship with their provider as a very important precursor to developing trust. So with the trust in relationship, participants felt more comfortable talking to the provider about sensitive issues. We found that most people who participated in focus groups talked about not being honest with the provider. With the trust in relationship they felt more comfortable to talk about those things that they typically didn't, expressing preferences and being honest with their provider.

Also, with a trusting relationship, participants had an increased perception of provider credibility, and that was particularly true with young people, which resulted in improved medication and care plan adherence, a positive sense of well-being and an improved hope of recovery. So across all cultural groups, participants described provider cultural racial similarity as a factor that contributed to their positive experiences with care. Some cultural and racial similarity also facilitated relationship and trust with providers.

People for whom English was not their primary language, stressed the importance of having a provider who speaks their language. Having interpreters who speak their language was met with mixed opinions. Interpreters who only interpreted and were brought in the exam room once the respondent was placed there and who did not interact beyond interpreting were generally appreciated but not valued. Whereas, interpreters who met with the participant while waiting for the provider, would talk to them, ask questions about their family and remember their situation at the next visit, ask if you need resources and if the person had ready information were much valued.

Particularly the latter experience with the interpreters that did spend time with them, did get engaged with them, did ask about their family also had a more positive perception of care. They expressed a higher degree of trust and confidence in their provider. Remember, confidence is very much related to adherence to any kind of care plan, whether you just hear

it and you're polite and shake your head yes and go home but then not doing that, or whether you just trust that even if you start taking the medication you feel rotten for a week and your providers knows and cares.

It makes a big difference. So, expressing a higher degree of trust and confidence in the provider, expressed a greater degree of wellness and health, even when experiencing serious illness. We had one person that was experiencing stage four cancer with mental illness and had hope for the future and felt like they had the best health and wellness they could have. We attributed that to the relationship they had with their provider.

So factors that contribute to trust include: asking questions about the whole person, instead of only focusing on the illness. To be wellness focused rather than illness focused. So instead of, you know, let's find out everything we need to know about the illness so we can treat it, it's "How can we get you well?". Let's deal with the illness in terms of what it's going to take to get you well. Self-disclosure... it's very interesting for young people, particularly African Americans, that was very important for a provider to say, if this was me this is what I would do or, I've been in this situation before this is what I did and this is how it turned out. Self-disclosure was huge.

To actively listen, means eye contact, it means asking questions and asking follow up questions about what they talked about when they come back. One follow up question about something, a family member, goes such a long way in establishing trust in the relationship, because it really says I heard you. Taking time to give and discuss information, rather than simply providing pamphlets. Of these 30 focus groups we talked to almost 250 people and I can tell you that of those people, when they got the pamphlets, usually when we're talking about mental health, it was at a time when they did not have what it took to read it, comprehend it and so handing people pamphlets was not how people learned. Most folks did not read them and opted instead to talk to someone they trusted, whether it was another family member or to look online.

Young people spend a lot of time looking online. Many of the Russian elders were looking online as a very prominent way to get information. However, the problem with that is that for many of the people living with a mental illness there are a lot of sites that would pop up that are damaging sites... maybe they said kill yourself here's how... so it's a huge problem and I heard it all across the state. A recommendation is to have a hub somewhere, a site where people can look up and go directly to the site instead of Googling it and run the risk of having all manner of other kinds of information pop up that may be detrimental to their health at that point in time.

Other factors that contribute to trust is the perception that the provider cares. I've heard that repeatedly and again if they felt the provider cared they were willing to go to treatments they normally would have been reluctant to go to. Over time they would begin to share information that was sacred.

So factors that impede trust include: rushing through an appointment, not being listened to or heard, recommending medication without enough perceived input from the patient to make a good recommendation for medication. This was another huge marker for people was that they felt they were only talked to for a matter of minutes and then they arrived at possibly a diagnosis or medication.

Case in point was a woman whose parent lived with severe schizophrenia and paranoia. There were 10 children in the family and for 12 years she did not speak to any of these children, she was afraid of them. They raised themselves and did the best they could. Somehow she was kidnapped and brutally raped and beaten. She ended up finally seeing a provider, who only asked her about her symptoms. What was missed was that discussion about what has happened to you, what brought you to this point, rather than just symptomology. It's really important to ask and talk long enough to understand what it is you're seeing in order to put it into perspective.

I think that goes back to what Mary Beth said about getting to know your client and their individual culture. What have they been through? How do they perceive being here and their mental illness and hope for wellness and recover?

So overall cultural groups expressed that they were not medication averse, however, most preferred to have a provider pursue natural or practical avenues before prescribing medication. So if their preference was to arrive at prescribing medication rather than starting prescribing medication, which begged the question... what other things do you do for mental health? There was a range of natural practices.

They mentioned things like ...

Yoga  
Reiki

And in some of the most unusual communities and in addition to the maladaptive kinds of things like marijuana use and that sort of thing. The Russian community, for example, had integrated medicine mind/body/spirit approach that they were accustomed to in their country and that doctors from their country still utilize. Most of the participants in focus groups talked about relief and value from non-traditional kinds of approaches to mental health issues and exacerbations.

Other factors that come into play are mental health literacy. Some communities have had absolutely no experience, knowledge or ability to understand the pamphlets that we hand out and much of the language we use. They've not talked to anybody who openly admits to having had a mental health issue. They don't know the literacy, they look at the pamphlet and they start on the continuum about a third of the way down and it pre-assumes you know, for example, what an assessment is. So the literature may say you need an assessment.

They don't know what an assessment is or even who to get one from. Who does an assessment? You add to that a community/culture that may have protected information or they don't share information readily and they don't have the knowledge that when you go for an assessment you'll be asked questions, so right away it sets up a scenario for lack of adherence or compliance, if you will.

Let's get into information about mental health and some medical information pre-assumes the level of mental health literacy that many cultural communities don't have.

Written materials provided to patients in cultural communities often do not take into account the lack of knowledge and experience many in cultural communities have. So some of them have had limited or no interaction with these symptoms, thus referencing, for example, as I said earlier an assessment in a pamphlet may be foreign. And, in communities where information routinely asked for in the course of an assessment is considered sacred, is guarded or is considered unsafe to divulge. It's important to inform the individual what types of questions they'll likely be asked.

The reason for asking, as a benefit of both asking the question and providing an honest answer. These are words directly from a number of young men, who need mental health services, but said if someone can just tell us what the benefit is. Focus groups revealed that many participants did not know or understand the benefit of being honest or the benefit or potential benefit of receiving mental health services. So they didn't even know what one could expect from getting mental health services.

So, in this instance, things to consider are:

How does education happen for patients whose primary language is not English or for patients who may be illiterate or may not have a written language?



In closing, probably the most important suggestion is to get to know your patients. In your first couple of appointments it's really important to take time to find out who they are, share who you are and what will be happening if there is a referral to mental health services. Take the time to inform people what to expect, because many people only know what they're heard and sometimes that's very inaccurate information. What kinds of questions will they ask? What's the benefit of answering them? And, what you can expect both from treatment, medication and let people know it comes down to their choice as well.

People often don't realize that it is, in fact, their choice. Thank you.

**Chelsey:** In an effort to equip providers with quick access to resources and tools for the treatment of depression and best practices for serving culturally diverse populations, this performance improvement collaborative has released a web based provider toolkit as is shown. The toolkit is interactive and can immediately direct you to each tool's exact source. The link on the bottom of the slide will take you to the toolkit that can be found on the Stratis Health anti-depressant medication management collaborative page.

As you can tell from the grid the toolkit has four key sections.

Best practices for depression care  
Cultural competency and treating depression  
Shared decision making for depression treatments  
Mental health resources

Some examples of the specific resources are listed on this slide.

- Clinical depression guidelines, the PHQ-9 screening method, and Stratis Health cultural care connections website as previously referenced. This website has self-assessment tools and information on various diverse populations.
- The Minnesota Shared Decision Making Collaborative and all of their work.
- The Mayo Clinic's shared decision making tools.
- The Joint Commissions Speak Up Campaign and
- NAMI's Make It OK campaign materials and much more.

We encourage the use of this toolkit and feedback.

Thank you to both of our speakers today and all our listeners. We hope you found today's webinar of value to you and your organization. If you have additional questions their contact information is in the slide deck and will be posted. We will also be sending out an email with an additional link for any general questions about the series or our collaborative.

Please remember to complete our post webinar survey and evaluation. If you're listening today as a group, please ask the person who registered for the group to forward the survey on. Your certificate of completion is connected to submitting the survey. Our slide deck, video recording, transcription of today's webinar will be available on the Stratis Health Collaborative web page, along with our provider toolkit.

Stay tuned for future webinars from our collaborative and our series on Reducing Racial Disparities and the Treatment of Depression. Have a wonderful rest of your day.