




A Global-Local Paradigm for Mental Health: A Model and Implications for Addressing Disparities Through Training and Research

Kristina J. Korte^{1,3} · Kimberly Hook^{2,3,7}  · Elizabeth J. Levey³ · Christine E. Cooper-Vince⁴ · Christy A. Denckla¹ · Senait Ghebrehiwet² · Rebecca S. Hock³ · Benjamin L. Harris⁵ · Jeremiah Menyongai⁶ · Tithi D. Baul² · Christina P.C. Borba^{2,7} · Gregory L. Fricchione³ · David C. Henderson^{2,7}

Received: 4 February 2022 / Accepted: 27 July 2022 / Published online: 9 August 2022

© The Author(s), under exclusive licence to American Association of Chairs of Departments of Psychiatry, American Association of Directors of Psychiatric Residency Training, Association for Academic Psychiatry and Association of Directors of Medical Student Education in Psychiatry 2022

Mental health disparities, described as differences between the quality, accessibility, and outcomes of mental health care between groups, are widely acknowledged in the literature and are likely to widen given the COVID-19 pandemic [1, 2]. We particularly highlight the significant mental health disparities that racially and ethnically minoritized groups, including immigrants and refugees, face [3]. At the same time, national census data indicate that the United States (U.S.) is becoming increasingly ethnically diverse each year [4]. In 2015, the total number of immigrants in the U.S. reached 44.9 million, up from 14.1 million in 1980 [5]. The varied cultural backgrounds and experiences among ethnically diverse populations influence their needs, engagement, treatment adherence, and health outcomes across both academic medical and community mental health care settings [6].

It is vital that the professional mental health community turn greater attention to culturally responsive approaches in clinical practice and research [3, 7]. These practices, which consider the role of culture on mental health expression and are based in knowledge of and respect for cultural background, are necessary to reduce mental health disparities [3]. One approach to ensure increased attention to culture in the local U.S. context is through development of training

programs that emphasize the knowledge to be gained by taking a global-local perspective to research and patient care.

One such program is the Global Psychiatry Clinical Research Training Program, currently a joint training fellowship between Boston University Medical Campus (BUMC) and Massachusetts General Hospital (MGH), which has been funded by the National Institute of Mental Health since 2012. The fellowship provides up to three years of postdoctoral support for trainees from mental health specialties (e.g., clinical psychology, psychiatry) to gain expertise in global mental health. The fellowship aims to develop independent and productive clinical investigators, and emphasizes creation of collaborative partnerships and bidirectional (i.e., mutually beneficial) capacity building to improve population health in both directions. Thus, lessons learned from global work have direct implications for the U.S., where there continue to be disparities in accessing quality care for traditionally underserved groups [8].

In this educational case report, we provide an example of our work and describe our shift towards a global-local paradigm that improved our knowledge of culturally responsive responses in clinical practice and research contexts (see Table 1). Here, “global” refers to work conducted in Liberia, as well as work conducted with research partners outside of the U.S., while “local” references domestic (i.e., within the U.S.) efforts. Stemming from this overview, we conclude by offering suggestions for how this type of bidirectional knowledge flow has relevance for current practices in mental health training and offers opportunities to effectively orient practitioner-scholars towards culturally responsive approaches in work domestically and abroad. We posit that a global-local perspective has great value for training, just as it does in increasing overall knowledge of mental health worldwide. Although this educational case report discusses Liberia as an example, the implications discussed are applicable to our experiences working with other low- and middle-income countries.

✉ Kimberly Hook
kimberly.hook@bmc.org

¹ Harvard T.H. Chan School of Public Health, Boston, MA, USA

² Boston Medical Center, Boston, MA, USA

³ Massachusetts General Hospital, Boston, MA, USA

⁴ University of Geneva, Geneva, Switzerland

⁵ University of Liberia, Monrovia, Liberia

⁶ Christ Jubilee International Ministries, Lowell, MA, USA

⁷ Boston University School of Medicine, Boston, MA, USA

Table 1 The global-local paradigm: Key lessons learned

- Global work can inform local work.
- Working with global populations can inform mental health care for immigrant populations in the U.S.
- Local work with immigrant populations can inform global work.
- Working with local immigrant populations can inform mental health care globally (e.g., in Liberia).
- The assessment and measurement of mental health constructs in immigrant populations and in global settings can be improved by altering the tools to include culturally specific terminology
- Programs taking a “global-local” perspective in training can help bridge the gap in providing culturally responsive care for the diverse U.S. population.
- Providing opportunities to work in global settings or with diverse populations in the U.S. can increase the use of a global-local perspective in research and patient care.

The Global-Local Paradigm: the Case of Liberia and Lowell, Massachusetts (MA)

The global-local paradigm harnesses insights gleaned from mental health research conducted in international settings to inform assessment and delivery of health services among ethnically diverse immigrant populations. This construct is illustrated through our experiences conducting collaborative mental health research and informing policy making in Liberia, which in turn led to opportunities to collaborate with the African immigrant community in Lowell, MA.

Briefly, our collaboration in Liberia began in 2009, when our group was invited to collaborate with the Liberian Ministry of Health and Social Welfare to create the first comprehensive mental health policy for the country. To build upon previous work [9] and inform policy development, several studies were conducted to better understand the existing mental health needs among Liberians. The extant literature indicated a high overall prevalence of mental illness and substance use, and to expand upon these existing data, our team returned to Liberia and conducted a mixed-methods study [10–12] in partnership with local colleagues to learn more about the mental health needs of children, adolescents, and young adults. Subsequent work used qualitative methods to explore a number of specific areas, such as patterns of substance use [13, 14].

After returning to Boston, our team initiated a partnership with local Liberian immigrants in order to transcribe and culturally interpret the qualitative interviews. To do this, we engaged Christ Jubilee International Ministries in Lowell, MA, which serves a large community of African immigrants, including a group of Liberian immigrants and refugees. When the pastor learned of the project, he was enthusiastic about the opportunity to help those in Liberia, and he recruited several parishioners to assist with transcription. Anecdotally, the local

Liberian and African immigrant community members expressed to our research team that their willingness to participate was largely driven by a desire to help individuals still living in Liberia. To prepare for this work, the parishioners, the majority of whom were from Liberia, were trained in qualitative methods (including data analysis) and worked closely with the U.S.-based team to refine findings.

Critically, our local work with parishioners guided our understanding of linguistic and cultural nuances, which allowed us to recognize our gaps in cultural knowledge and opportunities for improving our future research efforts. To illustrate, our local partners informed us that the assessment measures typically used in studies fail to use local terminology, such as “Big Mama” (i.e., an alcoholic beverage) to describe commonly used substances, which likely lead to an underestimation of substance use. Learning from this process, we altered the survey questions in subsequent research in Liberia to better reflect commonly used phrasings, in order to increase the cultural validity of our measures and more accurately capture rates of substance use. Similarly, the transcription process highlighted culturally specific understanding of and attitudes towards mental illness among the Liberian immigrant community of Lowell and individuals in Liberia. The Liberian immigrant community was struck by the similarities between symptom expression by individuals in Liberia and by those in their community in Lowell, MA.

Interestingly, the transcription process allowed our local Liberian and African partners to identify that many of the mental health issues discussed in our interviews conducted in Liberia were equally pervasive in their own community in Lowell. Liberians in Lowell observed that people within their community had limited understanding of mental health and utilization of services. As a result of this community-identified need, the Health and Mental Health Education and Awareness for Africans in Lowell (HEAAL) was co-founded with Christ Jubilee International Ministries in 2014 with the goal of informing the development of mental health resources tailored to the community’s needs [15]. One translator noted, “Even though we are here in America, we are still the same Africans. We still have the same beliefs. We still handle mental health issues and emotional health issues the same way” [16]. It is clear from this statement that the use of traditional approaches developed in the U.S. and other high-income countries to diagnose, assess, and treat mental health issues was limited in the degree to which they could address to the needs of immigrant populations and therefore, resulted in reduced ability to provide culturally responsive care for diverse populations. Ultimately, this collaboration led to the development of an ongoing relationship between the community and our research team, deepening both the researchers’ and community’s understanding of mental health needs in Liberia and Lowell.

The Global-Local Paradigm: Implications for Training

As described above, there are tangible benefits to integrating a global-local perspective into our approach. For example, our local community better recognized their needs for mental health care and were open to further engagement with mental health providers, and our global work was strengthened after including our local partners' knowledge into our data collection and interpretation. Through the use of our bidirectional approach, we discovered commonalities (i.e., similarities) between study findings from Liberia and those in the Liberian and African immigrant community in Lowell.

Additionally, outside of the direct impacts to the global and local Liberian population, this type of bidirectional learning offers opportunities for training psychiatrists, clinical psychologists, and allied mental health professionals (professions in the fields of Behavioral Analysis, Educational Psychology, Marriage and Family Therapy, Mental Health Counseling, and Rehabilitation Counseling), even in programs not focused on global engagement. We specifically note the importance of engaging trainees in these types of opportunities. Below, we highlight key areas stemming from our work with Liberian partners domestically and abroad.

Working Towards Cultural Humility

The U.S. and necessarily our patients are increasingly diverse [5]. For example, Boston Medical Center, which administers the BUMC-MGH Global Psychiatric Clinical Research Training Program, serves an exceptionally diverse patient population; 70% of patients presenting for care are non-Caucasian and approximately 38% were not born in the U.S. This is not a unique example and underscores the need for globally informed approaches to care in ethnically diverse populations. In order to effectively and respectfully provide mental health care to a wide range of patients, it is of paramount importance that allied mental health trainees begin the lifelong process of working towards cultural humility [17]. In our experience, engaging with our local partners in Lowell presented a prime opportunity to self-reflect on assumptions about presentations of mental health and substance use among the Liberian population. Developing awareness of our backgrounds and how our experiences influence our perspectives is a key ingredient of working towards cultural humility.

Though particularly relevant in global work, trainees in all settings, including domestic, must work towards being culturally responsive and sensitive when providing mental health services. Academic education is appropriately and increasingly focusing on culturally sensitive mental health practice, which is reflected in training guidelines from main oversight bodies such as the Accreditation Council for Graduate

Medical Education [18] and the American Psychological Association [19]. Greater focus on pathways to foster work with diverse community groups, such as with local community partners who may have strong cultural ties to global regions, may be valuable in driving growth towards this competency area.

Learning to Engage with Local Communities

Relatedly, bidirectional learning and engagement offers opportunities to practice developing lasting, impactful collaborations, including with service recipients and other community members. In our example, we significantly relied on the expertise of our local community partners to interpret and contextualize data collected in an international setting. We believe that when working across cultures, contexts, and socioeconomic settings, all research partners must take an active role and be given a voice in the process. In our work in Lowell, our partners identified processes that would encourage participation in local community health events and were active in making decisions that were responsive to community norms.

Existing training recommendations note the value of engaging in community-based work outside of health care settings [3, 17]. These training opportunities provide trainees with the opportunities to learn in nontraditional venues, enhance their exposure to diverse environments that may not typically be part of the curriculum, and offer an opportunity to practice cultural humility and develop competency towards culturally sensitive approaches, thereby working towards reducing mental health disparities.

Assessing Mental Health Across Cultures

Considering how mental health professionals assess mental health across cultures was a key area of learning throughout this project. In our work with the African immigrant community of Christ Jubilee International Ministries in Lowell, we realized that the assessment tools needed to be validated among ethnically diverse local populations in the U.S., as well as among diverse global populations. Although the need to adapt our tools of measurement in global contexts is well-known [1], our experience in Lowell highlighted the importance of ensuring that our tools are not only adapted for use in global settings such as Liberia, but that those adaptations are also applied to the local immigrant and migrant populations within the U.S. [1].

Finding the balance between global similarities and local differences is identified as a best practice in global mental health [20] and is highly relevant to work with diverse groups in the U.S. One example involves considering how cultural background and acculturation levels might impact perspectives and descriptions of mental illness is a key challenge in

Table 2 Impacts from bidirectional learning for global and local Liberian populations

	Global Liberian-based benefits	Local Liberian-based benefits
Opportunity to engage community in Lowell		X
Improved understanding of mental health through the Health and Mental Health Education and Awareness for Africans in Lowell (HEAAL) project		X
Understanding of how research can be used in pragmatic ways (e.g., resulted in accurate understanding of adolescent substance use behaviors)	X	X
Opportunity to assist community in Liberia	X	
Providing research training for Liberian psychiatry residents (in subsequent projects building from this work)	X	
Allowed Liberian psychiatry residents to have hands-on practice with data collection and analysis (in subsequent projects building from this work)	X	

any setting. Valid and reliable diagnostic assessments and culturally based modifications to treatments are critical components of delivering effective mental health treatment to ethnically diverse groups [6, 20]. The experience of working in global settings has highlighted the importance of also working alongside local groups to improve our understanding of what is universal and what is specific. Where possible, providing training opportunities that allow for experience working in global settings, as well as with diverse populations locally, can increase the use of a global-local perspective in research and patient care.

Conclusion

A paradigm shift towards a global-local understanding can promote best practices for mental health care among increasingly diverse U.S. populations. Using a case study of Liberia and Lowell, MA, we discuss bidirectional transfer of knowledge in cross-cultural practice (see Table 2) and identify corresponding areas of training that have relevance for individuals in any allied mental health training program. This approach may serve as a model for other training programs, even if not globally focused. A global-local approach can enhance cultural awareness and humility, improve ability to work alongside diverse community members, and ensure that research and patient care are rooted in cultural competency, thereby taking a step towards reducing health disparities. As the COVID-19 pandemic continues to alter the way society lives and to affect how mental health professionals deliver care and conduct research, telehealth and distance training are becoming increasingly common. Global-local perspectives will only become more critical as these trends continue.

Acknowledgements The authors have informed the journal that they agree that both Kristina Korte and Kimberly Hook completed the intellectual and other work typical of the first author.

Declarations

Disclosures Research reported in this publication was supported by the National Institute of Mental Health under award numbers T32MH093310, T32MH116140, K23MH117278, and K23MH115169, as well as the Fogarty International Center and National Institute of Mental Health, of the National Institutes of Health, under Award Number K01TW012180 and D43TW010543. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. CAD reports association with Evermore as a Scientific Advisory Board Member. GLF reports payment for CME talks at Harvard University, membership on the Rosalynn Carter Institute Board of Directors, and royalties from work published through the University of Chicago Press, Johns Hopkins University Press, APA Press, Elsevier Press, and Belvoir Press. The other authors have nothing to disclose.

References

1. Safran MA, Mays RA Jr, Huang LN, McCuan R, Pham PK, Fisher SK, McDuffie KY, Trachtenberg A. Mental health disparities. *Am J Public Health*. 2009;99(11):1962–6. <https://doi.org/10.2105/AJPH.2009.167346>.
2. Yang J, Landrum MB, Zhou L, Busch AB. Disparities in outpatient visits for mental health and/or substance use disorders during the COVID surge and partial reopening in Massachusetts. *Gen Hosp Psychiatry*. 2020;67:100–6. <https://doi.org/10.1016/j.genhosppsy.2020.09.004>.
3. Mongelli F, Georgakopoulos P, Pato MT. Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus (Am Psychiatr Publ)*. 2020;18(1):16–24. <https://doi.org/10.1176/appi.focus.20190028>.
4. United States Census Bureau [Internet]. 2020 U.S. population more racially and ethnically diverse than measured in 2010; 2021 Aug 12. Available from: <https://www.census.gov/library/stories/2021/08/2020-united-states-population-more-racially-ethnically-diverse-than-2010.html>. Accessed 26 Jul 2022
5. Gibson C, Jung K. Historical census statistics on the foreign-born population of the United States, 1850 to 2000. Population Division, US Census Bureau Washington, DC; 2006.
6. Hinton DE, Patel A. Cultural adaptations of cognitive behavioral therapy. *Psychiatr Clin North Am*. 2017;40(4):701–14.
7. Holden K, McGregor B, Thandi P, Fresh E, Sheats K, Belton A, Mattox G, Satcher D. Toward culturally centered integrative care

- for addressing mental health disparities among ethnic minorities. *Psychol Serv*. 2014;11(4):357–68. <https://doi.org/10.1037/a0038122>.
8. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):629–40.
 9. Republic of Liberia Ministry of Health and Social Welfare [Internet]. National mental health policy; 2009. Available from https://www.resilientinstitutionsafrica.org/sites/default/files/files/2017/Liberia-National_Mental_Health_Policy.pdf. Accessed 26 Jul 2022
 10. Harris BL, Levey EJ, Borba CP, Gray DA, Carney JR, Henderson DC. Substance use behaviors of secondary school students in post-conflict Liberia: a pilot study. *Int J Cult Ment Health*. 2012;5(3):190–201.
 11. Levey EJ, Borba CPC, Harris BL, Carney JR, Domínguez S, Wang EKS, et al. Assessment of the needs of vulnerable youth populations in post-conflict Liberia. *Afr J Psychiatry (Johannesbg)*. 2013;16(5):349–55.
 12. Borba CP, Ng LC, Stevenson A, Vesga-Lopez O, Harris BL, Parnarouskis L, et al. A mental health needs assessment of children and adolescents in post-conflict Liberia: results from a quantitative key informant survey. *Int J Cult Ment Health*. 2016;9(1):56–70.
 13. Pullen SJ, Petruzzi L, Lange BC, Parnarouskis L, Dominguez S, Harris B, et al. A qualitative analysis of substance use among Liberian youth: understanding behaviors, consequences, and protective factors involving school youth and the school milieu. *Int J Ment Health Psychiatry*. 2016;2(1). <https://doi.org/10.4172/2471-4372.1000116>
 14. Petruzzi LJ, Pullen SJ, Lange BCL, Parnarouskis L, Dominguez S, Harris B, Quiterio N, Lekpeh G, Manobah B, Henderson DC, Borba CPC. Contributing risk factors for substance use among youth in postconflict Liberia. *Qual Health Res*. 2018;28(12):1827–38.
 15. Oppenheim CE, Axelrod K, Menyongai J, Chukwuezi B, Tam A, Henderson DC, Borba CPC. The HEAAL project: applying community-based participatory research (CBPR) methodology in a health and mental health needs assessment with an African immigrant and refugee faith community in Lowell, Massachusetts. *J Public Health Manag Pract*. 2019;25(1):E1–6.
 16. Oppenheim CE. A detailed analysis of a mixed-method, quantitative and qualitative, “Needs Assessment for Health and Mental Health Education and Awareness for Africans in Lowell” (HEAAL) research project [master’s thesis]. Boston, MA: Department of Global Health, Boston University School of Public Health. 2016.
 17. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9(2):117–25. <https://doi.org/10.1353/hpu.2010.0233>.
 18. Accreditation Council for Graduate Medical Education. ACGME: Common program requirements (Residency). 2020. <https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf>. Accessed 17 Dec 2020.
 19. American Psychological Association. Multicultural guidelines: an ecological approach to context, identity, and intersectionality. 2017. <http://www.apa.org/about/policy/multicultural-guidelines.pdf>. Accessed 17 Dec 2020.
 20. Kohrt BA, Rasmussen A, Kaiser BN, Haroz EE, Maharjan SM, Mutamba BB, de Jong JT, Hinton DE. Cultural concepts of distress and psychiatric disorders: literature review and research recommendations for global mental health epidemiology. *Int J Epidemiol*. 2013;43(2):365–406.

Publisher’s Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.