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Cultural influences in mental health treatment

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Abstract

Research on mental health treatments from 2010 to 2015 has continued to highlight the critical role of culture on treatment services, processes, and outcomes for racial/ethnic minority groups. Studies showed that factors such as acculturation and phenotypic appearance were associated with risk for psychopathology. Issues such as face concern and acculturation level were associated with the quality of client–therapist relationships and the amount of information clients disclosed in sessions. While racial/ethnic minority clients generally preferred same-ethnicity therapists, findings showed relatively small effects for racial/ethnic match and positive treatment outcomes. Several studies provided additional evidence for the effectiveness of culturally-adapted, evidence-based treatments compared to non-adapted treatments for minority clients, and more researchers are beginning to delineate the processes involved in making these successful adaptations.

Racial/ethnic minority populations continue to grow in the U.S. The most recent U.S. Census showed that Hispanic/Latinos comprised 17.4% of the U.S. population, and Asian Americans experienced the fastest rate of growth — over 40% — from 2000 to 2010 [1]. It is projected that the U.S. will achieve majority–minority status by 2044, and almost 70% of the nation's children will be part of a minority race/ethnic group by 2060 [1]. The diversification of the U.S. is occurring quite rapidly, and mental health researchers are working to respond to the needs of a multicultural society.

Disparities in poor utilization and quality of mental health treatments for African Americans, American Indians, Asian Americans, and Latino/as have been documented for many decades [2,3], and they continue to persist. We review the recent research on cultural issues in mental health and mental health treatments, highlighting the important empirical work that has been conducted in the past five years. We conclude with a discussion of trends and future directions in this area of research.

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Conflict of interest statement

Nothing declared.

Cultural variations in mental health disorders, treatment processes, and outcomes

One critical area involves the identification of factors that may influence mental health treatment outcomes for racial/ethnic minority clients. Important differences between racial/ethnic minority and majority groups have been observed in rates of mental health disorders or problems, in perceptions of treatment effectiveness, and in treatment outcomes. This area of research determines how cultural factors can be addressed to decrease disparities in mental health for ethnic minority groups.

Mental health disorders

Despite the fact that ethnic minority clients tend to have similar rates of psychopathology, they utilize mental health services at lower rates compared to Whites and to their level of mental health needs [3]. Asian American patients who utilized inpatient services had more severe psychiatric diagnoses (i.e., schizophrenia, psychotic disorders) compared to White inpatients [4], supporting previous research indicating that distress levels are high by the time Asian clients reach the point of accessing services. Additional studies found that while Asian Americans have low rates of substance abuse relative to other racial/ethnic groups, those who are heavy drinkers are more likely to suffer from mental health problems [5]. Culturally-related factors are often associated with the differing rates of mental health disorders for minority groups. Specifically, Latino adults who were more acculturated to mainstream U.S. culture were at more risk for depression compared to Latino adults who were less acculturated to U.S. culture, suggesting that maintaining cultural ties to one's culture of origin may be protective [6]. Bicultural competence (i.e., the ability to identify and be proficient in the host culture as well in one's culture of origin) also was a protective factor against minority stress. College students with high levels of minority stress (e.g., stress that is experienced by a person who is part of a stigmatized group) were less likely to have depressive symptoms if they had high bicultural competence [7]. Black, Hispanic, and Other (e.g., Asian) adults in a nationally-representative sample were more likely to experience emotional stress from experiences of perceived racism compared to White adults, and this stress was positively associated with physical health problems [8]. Additionally, racial/ethnic minorities' low adherence in taking antidepressant medications may contribute to poor health outcomes [9].

An emerging and interesting area of research has examined the association between one's phenotypic characteristics (often associated with ethnicity and/or race) and rates of psychopathology. Specifically, first-generation Mexican adolescents (i.e., born outside of the U.S.) and second-generation (i.e., born in the U.S. to immigrant parents) with more indigenous ethnoracial appearances were at lower risk for using alcohol, cigarettes and marijuana, while those with more European appearances were at higher risk for drug use [10•]. However, for third-generation (i.e., U.S.-born parents) Mexican adolescents the pattern of findings was reversed. The authors posit that indigenous ethnoracial features served as a proxy for cultural pride and were more salient for adolescents who were recent immigrants or had closer ties to their Mexican cultures [10•]. Thus, third-generation adolescents who were indigenous in appearance but were more removed from immigration

experiences were more likely to feel more distress when they perceived discrimination based on their appearance, placing them at higher risk for substance use. The research underscores how various aspects mapping onto culture, even physical characteristics, can affect mental health problems or outcomes.

Perceptions of mental health and treatments

Recent studies suggest that racial/ethnic minority clients continue to perceive mental health problems differently than members of the majority group, which may influence their help-seeking behavior. Hispanic, Black, and Asian adolescents were more likely than Whites to believe that externalizing behaviors, such as getting into fights, problems with other people, or problems at school, are reasons for receiving mental health treatment [11•]. Conversely, White adolescents were more likely than their minority peers to endorse internalizing problems such as feeling depressed or anxious [11•]. These findings suggest that members of the minority groups may hold certain cultural beliefs or norms (e.g., stigma) associated with mental illness or mental health treatments that influence their recognition of or desire to utilize mental health care. In the case of internalizing problems, there may be different cultural thresholds for the tolerance of personal distress that may then affect one's decision to seek treatment. For example, there is a common Buddhist belief that 'life is suffering.' If suffering (i.e., personal distress) is seen as a natural part of life, this may account for why many East Asians often may not seek treatment of internalizing issues.

Treatment processes and outcomes

Cultural factors that influence treatment processes and outcomes continue to become a main focus of mental health treatment research for ethnic minority clients. Treatment process research focuses on the factors that influence the treatment process, such as client disclosure (i.e., how much clients divulge in therapy) or working alliance (i.e., the relationship between client and therapist). Treatment outcomes research focuses on the outcome of therapies, such as reductions in psychological distress (e.g., reduced depression levels). Research on both treatment processes and outcomes has identified the critical role of face concern. Face is defined as a person's own claims about their social character and integrity, and is part of the roles they carry out as a member of a specific social group [12]. Face concern was negatively associated with disclosure of personal information [13•]. Lower acculturation to U.S. culture also was associated with less disclosure, but this was mediated by face concern [13•]. Other studies provided some clarification for the mixed effects of therapist–client racial/ethnic match on treatment outcomes. Specifically, ethnic minority clients prefer to seen by therapists of the same race/ethnicity and tend to have more confidence in their therapists and their skills [14••,15,16•]. Regardless of race/ethnicity, clients rated their therapists as more supportive if they perceived their therapists to be have similar life experiences, attitudes, values, and personality [15]. This perception was positively linked with working alliance and therapist credibility (i.e., how credible clients perceive their therapists) [15].

Despite client preferences for racial/ethnic match, evidence suggests that ethnic match may not be a strong predictor of positive treatment outcomes [14••]. African American clients were the only minority group where racial/ethnic match appeared to be strongly related to client preference, positive perceptions of therapists, and positive treatment outcomes [14••].

Other than African American clients, the research indicated that racial match may influence treatment processes (e.g., engagement, retention), but not the outcomes of treatment (e.g., reduced distress or symptoms). That is, racial/ethnic match between client and therapist may strengthen or support clients' positive perceptions of their therapists, but other factors (e.g., cultural competence or counseling style of the therapist) may have more direct effects on treatment outcomes.

Therapist factors in treatment processes and outcomes

Several recent studies have examined the influences of therapist characteristics, such as ethnicity, birthplace, and acculturation level on treatment processes and outcomes. Clients and therapists were matched based on their place of birth (i.e., Mexico, Puerto Rico, Cuba, or U.S.) and acculturation level to American and Hispanic cultures [17]. Matches in birthplace and acculturation were associated with increased client participation in treatment and decreased substance use for Hispanic outpatient clients [17]. This research suggests that client–therapist matches on variables related to ethnicity and race such as nativity, acculturation level, enculturation level, etc. may be a more informative way to examine how cultural matches affect treatment processes and outcomes.

Other studies have examined the importance of a strong client–therapist alliance (i.e., positive therapeutic relationship) and identified several factors that are significant contributors to positive therapist–client relationships. For example, having a strong therapist–client relationship mediated the negative association between experiences of microaggressions and psychological health [18]. That is, clients who reported more experiences of microaggressions reported poorer psychological health; however, clients who had positive relationships with their therapists fared better than those who experienced microaggressions but had poorer relationships with their therapists [18]. Regardless of racial/ethnic background, therapists who had greater multicultural awareness had better counseling relationships with their clients [19••]. Similarly, therapists who had higher levels of ethnic identity, increased awareness of racial oppression, and an understanding of White privilege rated themselves as more culturally competent and sensitive to their clients' needs [20]. These findings point to the possibly important role of multicultural awareness — therapists who are sensitive to the cultural considerations necessary in working with racial/ethnic minority clients may be more effective in attending to and addressing important cultural aspects of treatment for these clients.

In fact, when cultural considerations are ignored, this may adversely affect the treatment experiences and outcomes for racial/ethnic minority clients. In a qualitative study of mental health professionals, therapists who failed to address issues of race/ethnicity, gender, and socioeconomic status in their case conceptualizations of a sample case study also disproportionately diagnosed ethnic minority clients with bipolar disorder compared to White clients [21]. Thus, neglecting cultural factors, intentional or unintentional, may lead to misdiagnoses and inaccurate treatment recommendations for minority clients.

Cultural adaptations of evidence-based treatments

Given the persisting mental health disparities in quality of care among ethnic minority clientele, there remains a critical need for developing and/or adapting treatments and interventions that are culturally relevant, appropriate, and acceptable [22,23,24•,25••,26] In a qualitative study, the majority of therapists described adapting treatments for their ethnic minority clients by using strategies such as cultural brokering and providing culturally sound psychoeducation [27]. While these strategies are suitable, experts argue that many evidence-based treatments (EBT) already exist that may be appropriate for racial/ethnic minority populations, such as mindfulness-based therapies for Asian Americans [23] and Multi-Systemic Therapy (MST) and parent training for ethnic minority children, that are both culturally sensitive and grounded in empirical support for effectively treating mental health difficulties [25••,28]. As a result, researchers have begun calling for the use of evidenced-based psychological practice, which seeks to use EBTs with high fidelity (i.e., following the treatment protocols as closely as possible) while integrating factors relevant to the client's culture into the treatment and adapting the intervention for use within culturally important systems (e.g., schools, primary care settings, churches). In essence, this practice calls for the need and use of empirically supported, culturally-adapted interventions [25••].

The effort to identify evidence-based psychological practices in recent years has resulted in a growth of studies examining the effectiveness of culturally adapted interventions. Randomized control trials and quai-experimental studies of adapted EBTs have been conducted for various mental health outcomes (e.g., depression, phobia) and for many populations, including migrant farmworkers, Hispanic populations, and Asian Americans; these findings provide more support for the effectiveness of culturally adapted EBTs at decreasing distress and symptoms [29,30]. A pretest–posttest study found that female migrant farmworkers who participated in a culturally-tailored cognitive-behavioral therapy (CBT) support group experienced a significant reduction in depression, anxiety, and stress from pretreatment to posttreatment to 6-month follow-up [29]. In addition, Asian Americans less acculturated to mainstream American culture benefited more from a culturally-adapted, brief exposure therapy for phobias compared to less acculturated Asian Americans receiving the standard exposure therapy condition [30]. Several meta-analytic studies have provided evidence for the superior effects of culturally-adapted EBTs compared to the unadapted treatment, treatment as usual, or waitlist control [31,32••,33••]. For example, high effect sizes were documented for culturally adapted psychotherapies over conventional psychotherapy for ethnic minority clients, with standard mean differences ranging from .72 to 1.06 [32••,33••]. These findings were found for both adult and psychotherapies, though effect sizes were higher for adult therapies [34].

Research evaluating the effectiveness of culturally adapted EBTs has increased significantly in recent years, but the processes by which researchers are adapting these treatments are not well articulated. In fact, one review of adapted treatments for depression found that only two-thirds of the studies explicitly described their adaptation processes [32••]. Studies on adapted treatments often lacked specific guidelines and frameworks that directed the adaptation of a particular EBT [24•,35,36]. Recently, researchers have made efforts to better explain how the intervention was culturally adapted. For example, Hinton identified

the key elements of his empirically validated, culturally adapted treatment for Cambodian and Vietnamese refugees suffering from PTSD [24•]. Other conceptual frameworks of adaptions have been provided to better describe and justify the cultural adaptations for the following treatments: brief motivational interviewing for alcohol use with Latino adults [36], a telephone cognitive behavioral depression intervention for Latinos [37•], parent training models [35,38], and ecological prevention interventions for low-income minority youth [39] and Asian families with young children [40].

Conclusion and future directions

Researchers continue to disentangle and address the complexities of cultural issues in mental health treatment so that the field is progressing toward eliminating mental health disparities in quality of care in ethnic minority communities. The following areas of research will be necessary to bring about these changes, ultimately leading to improved mental health and psychological well-being for racial/ethnic minority populations.

Unpacking and deconstructing ethnicity

More specific knowledge on the psychological variations of specific ethnocultural groups is needed in order to fully understand the nuances of culture and its impact on rates of mental health disorders and response to treatment. For instance, Native Hawaiians and Pacific Islanders (NH/PI) are often categorized as Asian Americans. When these ethnic groups are separated, NH/PIs are characteristically different from Asians on certain demographic characteristics (i.e., lower education, lower income), have significantly higher prevalence rates of substance use, depression, and delinquency compared to other racial/ethnic groups, and may respond differently to certain interventions [41]. These ethnic group variations must be further investigated in order to fully respond to the mental health treatment needs of individual clients through evidence-based practice standards. More recent studies have examined specific psychological elements associated with ethnic or cultural group variations (namely, the specific aspects of culture) and how they affect an ethnic minority client's response to treatment. The shift to study variables such as cultural value orientation, cultural identity, ethnoracial appearance, coping orientation, emotion regulation style, shame, and stigma allows us to better explain and understand the specific effects culture may have on treatment processes and outcomes. By drawing on this research, more effective and culturally syntonic interventions may be designed because the adaptations in evidence based treatments can be tailored to specific aspects of the client's cultural background that affect treatment.

Inclusion of racial/ethnic minorities, immigrants, and communities in treatments and research

Researchers have made great efforts to include ethnic minorities in treatment research, but the majority of clinical trials on psychological interventions still lack sufficient samples of ethnic minority clients to analyze the effects of ethnic and racial status on treatment outcomes. Kataoka and colleagues put forth guidelines to promote evidence-based practice in research, which include the use of community-based participatory research to engage and develop partnerships in the development, design, and evaluation of EBTs with ethnic

minority populations [25••]. Clearly, one promising way to ensure good fidelity of culturally adapted EBTs and sustainability of these treatments involves developing and designing treatments in close collaboration with key stakeholders in ethnic minority communities so that cultural issues can be more effectively and systematically integrated into the context of treatment, thereby, optimizing the likelihood that the intervention is culturally informed in a proactive manner. This approach contrasts with the typical process in adaptation research in which an intervention is changed or modified to address cultural issues only after it has been validated with the mainstream population.

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