A PRISMA-driven systematic review for determining cross cultural mental health care

INTRODUCTION

Each population has its own particular cultural values and practices (Waite&Calamaro 2010). Culture has a critical role in human life in shaping the philosophy of life (Anderson et al. 2003). Culture is therefore an important consideration in health care. Cultural differences, may cause people to avoid accessing health care which can lead to health disparities between groups of people (Clark 2015). Culture has a direct relationship with help seeking behaviours and health care disparities (Corrigen et al. 2014). Such effects are perhaps more problematic in mental health settings, due to the sensitive nature of mental illness.

BACKGROUND

Culture is a complex concept including the beliefs, values, knowledge, law, morals, and norms of a society (Hedi et al. 2010). Culture is often static, closed and consistent, and these characteristics can lead to an understanding of 'the other'. In contrast, culture may reflect the flexibility, changeability and dynamic process-orientation created through communication and interaction (Mayer, 2011). In research on mental health, culture is often viewed in primordial ways, relating to the mental health of the nation, (Williams & Mohammed, 2009), and revealing the diverse constructs within cultures or cultural groups (Stewart, 2009). Lifestyles and beliefs, perceptions of physical and psychological wellbeing differ substantially across and within societies. In this sense, culture can be understood as not only habits and beliefs about perceived wellbeing, but also political, economic, legal, ethical, moral and health practices (Napier et al., 2014).

Mental health has relationship with psychosocial adaptation, work productivity, physical disease, health care utilization, and even mortality (Chida &Steptoe, 2008; Fleddurus et al., 2011). Mental health problems, in terms of cultural specific psychological themes, differ due to the clinical presentations, vulnerable populations, and barriers to treatment among populations (Chandra et al., 2016). Culture can therefore inform how mental health professionals develop the skills of observation, analysis and critical thinking, which are central to good mental health practice.

Maitra & Krause (2014) argue the need for specific training in cultural competency in order to gain greater insights in the field of mental health. However, the literature shows that quality of care to those displaying different cultural norms and behaviours is often poorer in

contrast to the majority population (Finkelstein et al. 2016; Hacker et al. 2015). This is typically due to lower cultural sensitivity of health care providers (Berlin et al. 2006). The major cultural issues arise from communication difficulties between service users and health care providers (Carroll, 2007), that impacts on the quality of care (Pergert, 2008). In mental health settings, people distressed not only by their illness, also experience stigma which is an important factor in care seeking behaviours and undermines the service system. Stigma is a complex construct that is affected by culture (Corrigen et al. 2014). Cultural perceptions often determine the social indicators of mental illness and influence tolerance of discrimination (Abdullah & Brown, 2011). Such norms inform the societal beliefs and values that comprise stereotypes which we learn as part of growing up in a particular culture, (Corrigen et al. 2014), which in turn impact the approaches taken by society toward health and illness.

Cultural competence in health is defined as a necessary capability that can be developed by health professionals to provide safe, effective and culturally sensitive care (Perng & Watson 2012). It is considered an essential component in providing effective and culturally responsive health care services in order to reduce health disparities (Papadopoulos, 2006) and in improve health outcomes (Shen, 2015). Culturally competent health care providers are more able to implement holistic care using cultural sensitivity, knowledge and skills and prevent cross cultural conflicts (Dougles et al. 2014; Leininger 2002, Jeffreys&Enis 2012). In contrast, cultural insensitivity and incompetence in the health care system can lead to barriers in health seeking behaviours (Rew et al. 2003).

Approaches to address such cultural insensitivity include the principles of Values-based Practice (VBP) which is a framework developed originally in the domain of mental health, that maintains that values, which are often culturally determined, are pervasive and powerful parameters influencing decisions about health, clinical practice and research (Petrova et al., 2006). VBP highlights the importance of clinical decision-making, in the presence of complex and conflicting values in healthcare (Fulford et al., 2016; Petrova et al., 2006) and in particular emphasises the need for practitioners to recognise their own values and respect the values of others, in order to bridge the values gaps that exist (Rankin, 2013). VBP provides practical skills and tools for eliciting individual values, enabling a greater understanding of the cross cultural issues that may support or inhibit successful healthcare.

Given the importance of culture and cultural competence in mental health care, there is a need to understand more deeply how to improve care pathways which address the core elements in providing cross-cultural mental health care. This study, through a systematic review of the literature, seeks to identify best practice and make recommendations for improvements in cultural competency and culturally sensitive care. We believe that the insights derived from this study will have wider relevance and appeal to countries facing similar challenges in meeting the growing cultural diversity of people experiencing mental health problems

METHOD

Aim

A PRISMA-driven systematic review was undertaken to determine how culture can affect mental health care delivery in order to make recommendations for improving care path-ways supported by culturally competent care.

Design

An extensive literature review was conducted, according to the guidelines proposed in the PRISMA statement (Moher et al. 2009). The systematic comparison and translation of the studies was guided by Noblit and Hare's (1988) meta-ethnographic approach. The meta-ethnographic approach involved identifying the intellectual focus of each article and determining the relevance of that focus to the aims of the study. Each paper was read and re-read several times by the researchers. Papers were then compared and grouped and finally they were synthesized and translated into themes to determine the relationships between each paper (Noblit & Hare, 1988).

Data collection

The databases of PubMed, CINAHL, and PsychInfo were searched for articles published in peer-reviewed journals since 2000, with the last search run in December 2018 and in the English language. The keyword search included a combination of the following terms: cross cultural mental health, cross cultural mental health care, trans cultural mental health, trans cultural mental health care.

The following inclusion criteria were assessed: (1) be written in English and published in a peer-reviewed journal; (2) include in the title or abstract at least one word related to

culture (e.g., race, ethnicity, immigrant, cross-cultural), clinician-service user interactions addressing culture and a clinical setting (e.g., hospital, clinic, primary care); (3) studies with adults (age 18 and over); (4) an analysis or discussion of cultural components. The exclusion criteria were: (1) Discussion articles and editorials, (2) articles that did not include research data from clinician-service user interactions, and (2) studies with children (age under 18).

Data Analysis

Thematic synthesis was adopted to analyse the results in order to identify important and similar data patterns (See Fig 2). The two authors made independent judgements as to whether the article met inclusion/exclusion criteria with particular focus on cross cultural mental health care. Disagreements were resolved by face-to-face discussion, leading to consensus judgement. The articles from the database search were subject to four levels of inclusion based on predetermined criterion.

- Level 1 search sought out the search terms identified above in the full text of articles and yielded 640 hits.
- Level 2 search examined the article titles and 448 hits.
- Level 3 search procedure (428 article hits), each abstract was examined for words or phrases that signalled inclusion or exclusion into the sample.
- In the Level 4 search, 112 articles were screened of full paper. Of the 112 articles from the Level 4 search, 12 met all inclusion criteria. Although three of the studies reported data from the same core author group (i.e., Alegria et al. 2008; Alegria et al. 2013; Alegria et al. 2014), the samples and aims were different.

RESULTS

Study characteristics

A total of twelve articles (Alegria et al. 2008, Alegria et al. 2013, Alegria et al. 2014, Blignault et al. 2008, Cortes et al. 2008, Jimanez et al. 2013, De Jesus and Earl 2014, Jimanez et al. 2015, Ishikawa et al. 2014, Mulvaney-Day et al. 2011, Simich et al. 2009) met eligibility criteria, as illustrated in PRISMA flow diagram (Fig. 1).

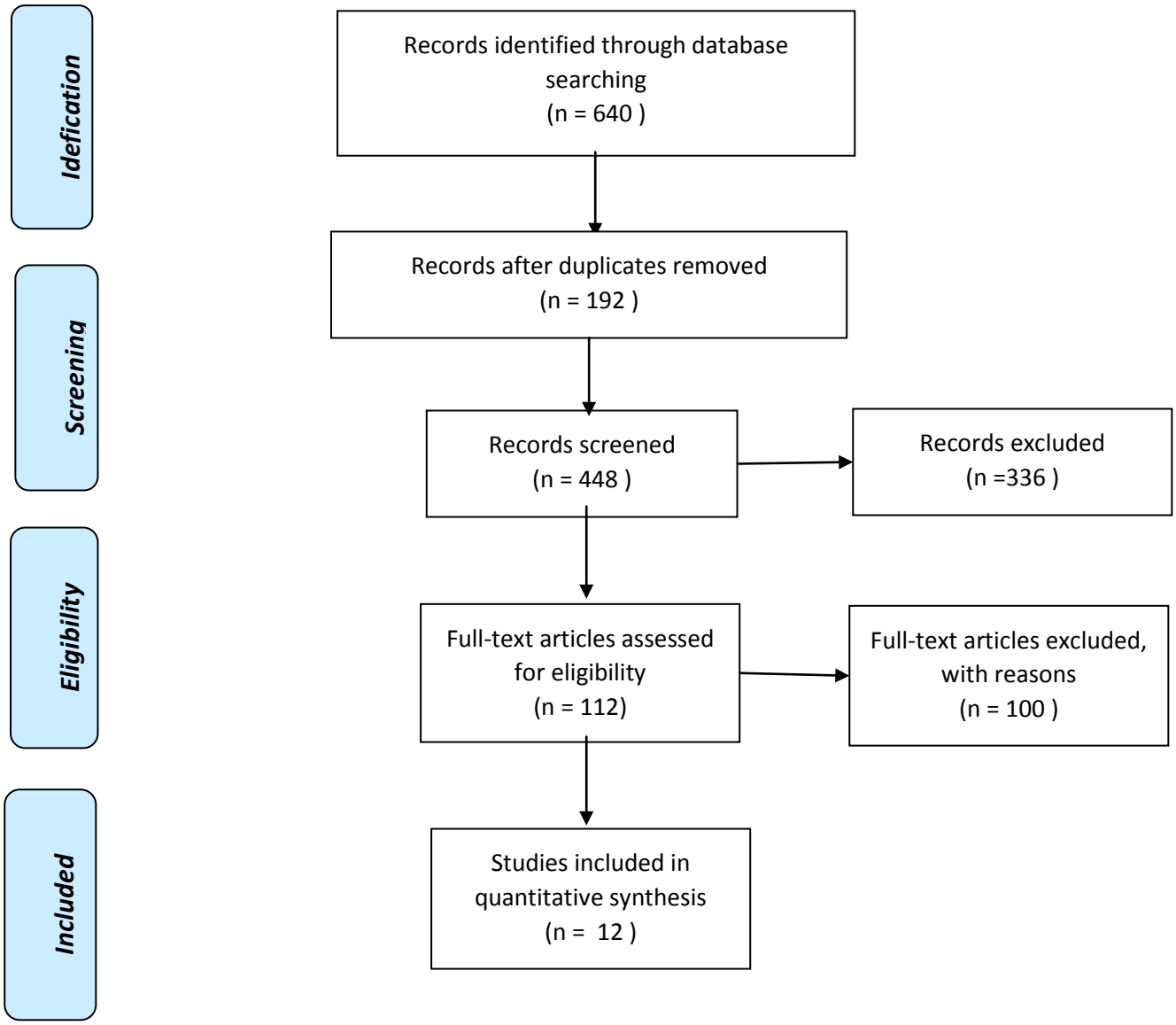

Fig 1. PRISMA Flow Diagram

The data from the studies are summarized and described in the Table below under the following headings: year and origin, research aim, design, study population, findings and conclusions.

All studies published between 2008 and 2015, that met the inclusion criteria were retrieved electronically. The origins of the studies were as follows, nine were from the US, one from Australia, one from Canada and one from Spain.

Of the studies 6 were qualitative (2 focus group and 4 in-depth interview) 6 were quantitative (3 RCT, 1 telephone interview, 1 observational study and 1 pre-post test design). 9 studies on effective strategies in mental health care for people from different cultural

background and 3 focused on the cultural effects on mental health care. The most common finding was that mental health disparities had negative effects on mental health and the use of services.

Table. Characteristics of Included Studies

Authors	*Year*	*Study Aim*	*Study Design*	*Study Population*	*Conclusion*	*Country*
Alegria et al.	2008	To develop and evaluate a patient self-reported activation and empowerment strategy in mental health care.	A pre/post test comparison group design	Latino and other minority patients	Results demonstrate the intervention's potential to increase self-reported patient activation, retention, and attendance in mental health care for minority populations	USA
Alegria et al.	2013	To examine how communication patterns vary across racial and ethnic patient- clinician dyads in mental health intake sessions and its relation to continuance in treatment.	Observational study	Latino patients and clinicians	Communication patterns seem to explain the role of ethnic concordance for continuance in care	USA
Alegria et al.	2014	Evaluate treatment effectiveness of telephone or face-to-face delivery of a 6-8 session cognitive behavioural therapy and care management intervention for low-income Latinos, as compared to usual care for depression	Multisite randomised controlled trial	Latino patients	The intervention appears to help Latino patients reduce depressive symptoms and improve functioning. Of particular importance is the higher treatment initiation for the telephone versus face to face intervention	USA
Ishikawa et al.	2014	To examine factors related to Latino patients' uptake of their PCPs' recommendations for depression treatment	Telephone interview	Latino patients	PCP's treatment recommendation and the PCP-patient alliance play a role in Latino primary care patients intention to follow a treatment recommendation for depression. An improved understanding of this role could enhance	USA

					efforts to improve depression treatment uptake	
Jimanez et al.	2012	Study applies the cultural influences on mental health framework to identify the relationship between race/ethnicity and differences in 1)beliefs on the cause of mental illness 2) preferences for type of treatment, and 3) provider characteristics.	A multisite randomized trial	Non Latino whites, African Americans, Asian Americans, Latinos,	Asian Americans, Latinos, and African Americans had different health beliefs regarding the causes of mental illness when compared with non-Latino whites. Race/ethnicity was also associated with determining who make healthcare decisions, treatment preferences, and preferred characteristics of healthcare providers.	USA
Simich et al.	2009	Presenting community perspectives on concepts of mental health, mental illness and mental health experiences with five ethno cultural communities.	Focus group qualitative	Latin American, Mandarin-speaking Chinese, Polish, Punjabi Sikh and Somali	Study illustrate the importance of the social context of immigration and settlement in conceptualizing mental health and mental distress.	Canada
Blignault et al.	2008	To understand subjective experiences of health and disease; social, cultural, and political influences on health and illness behaviour, and interactions with health services.	In-depth interviews qualitative	Service provider and community members	Participants identified several factors that limit access to mental healthcare as well as the quality of care received: mental health literacy, communication difficulties, stigma, confidentiality concerns, service constraints and discrimination.	Australia
Cortes et al.	2008	To teach skills in question formulation and to increase patients' participation in decisions about mental health treatment. To	Intervention design qualitative	Latino and low-income patients	Cultural and contextual factors can influence the experience of Latino's regarding participation in health care interactions.	Spain

		evaluate an action and empowerment intervention for mental health outpatients.				
De Jesus and Earl	2014	To identify indicators of quality of mental health care that matter most to two underrepresented immigrant patients groups.	Focus groups qualitative research	Brazilians Cape Verdeans	Provider performance was associated with five categories: relational, communication, linguistic, cultural, and technical competencies. Effectiveness of mental health care treatment was related to two categories: therapeutic relationship and treatment outcomes.	USA
Jimanez et al.	2015	To explore facilitators, barriers, and preferences for health behaviour change among Latinos with serious mental illness.	Qualitative research	Latinos	The primary facilitator identified by participants was having someone to hold them accountable for engaging in healthy behaviours.	USA
Mulvaney-Day et al.	2011	To analyze preferences for relational styles in encounters with mental health providers across racial and ethnic groups.	Qualitative research	African Americans Latinos Non-Latino whites	Awareness of subtle differences and attention to discomfort, because of professional and class distinctions, may help facilitate productive interchanges regarding the desire to connect across the differences, especially for some lower income non-Latino whites.	USA

Main Outcomes

Included studies were assessed by researchers independently and the findings of studies were grouped under 3 themes, titled 1) quality of cross cultural mental health care, 2) expectations

of people receiving cross cultural mental health care and 3) perspectives of health care providers on cross cultural mental health care (see Fig 2).

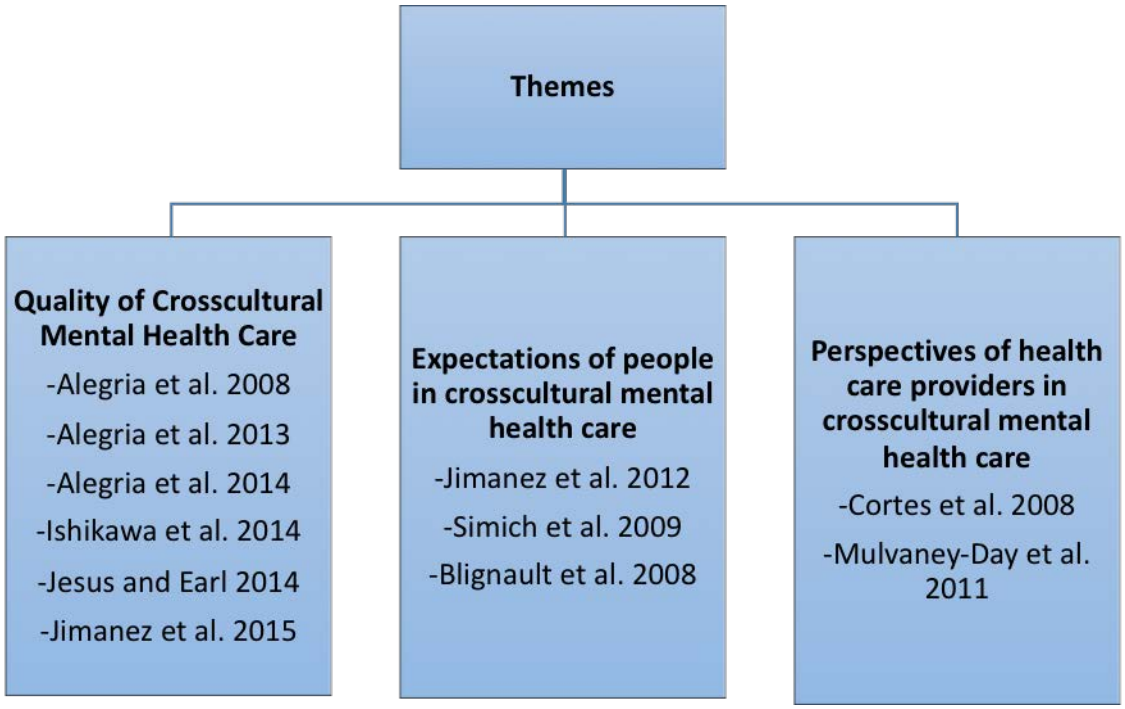

Fig 2. Thematic Synthesis of Studies

Quality of cross cultural mental health care

The effectiveness of mental health care for people from different cultures depends on the perceptions and expectations of service users and the approaches of health care providers. However, effective communication has a critical importance in providing culturally qualified care in mental health settings. A siginicant factor is the need for improved understanding of other cultures/ minority populations (Alegria et al. 2008, Alegria et al. 2013, Alegria et al. 2014, De Jesus and Earl 2014, Jimanez et al. 2015, Ishikawa et al. 2014).

Expectations of people receiving cross cultural mental health care

It was identified that service users from different cultures participate in decisions, interact with health care providers and are not victimized because of their culture in mental settings (Blignault et al. 2008, Jimanez et al. 2013, Simich et al. 2009).

Perspectives of health care providers on cross cultural mental health care

It is often remarked that cultural blindness of health care providers affects the health seeking behaviours of people with mental health issues. Also, service users can experience stigma and

non-therapeutic behaviours which leads to poor mental health care (Cortes et al. 2008, Mulvaney-Day et al. 2011).

DISCUSSION

It is evident from this review that the research literature on cross-cultural mental health care is still at an early stage of development. Consequently there are very limited studies determining the effect of cross cultural competency of health care providers in mental health or indeed the impact of cross cultural mental health care on service users. However, the limited literature retrieved will now be considered.

Quality of cross cultural mental health care

The values reflecting individual achievement and individualism have become important in cultural-sensitive care in mental health settings. Independent and interdependent self-appraisals are present in all cultures and the blend of the two constructs has unique consequences for the perception of mental health, depending on cultural qualities, values and the historical, political, and economic context (Santamaria, de la Mata, Hansen, & Ruiz, 2010). Cultural differences between service users and providers influence communication, clinical decision-making, and also service users' satisfaction, treatment adherence, and health outcomes (Paez et al. 2009). Consequently, supporting clinical decision-making, where complex and sometimes conflicting values are in play, needs to be determined with the use of VBP. Inconsistent care may result when health care providers fail to recognize and understand cultural values between service users and themselves.

It is clear there is a need for the teaching of cultural competence in mental health in order to better prepare the workforce. However, it is not a one-off, as continuing education in the dynamic environment of clinical care is needed for health care providers to stay abreast of cultural shifts in population in order to support the development of cultural competence in mental health services (Mareno & Hart, 2014; McClimens, Brewster, & Lewis, 2014). This review emphasises the relationship between quality of care, and cultural-awareness amongst qualified staff and suggests the need for wider investment.

Expectations of people in cross cultural mental health care

Understanding cultural values is an integral part of understanding mental health and ill-health (Avasthi, 2010). This impact can range from the effects on vulnerable individuals, through to

how culture shapes explanatory models and reactions to a mental psychopathology and the uniqueness of symptom expression (Alarcon, 2009; Viswanath and Chaturvedi, 2012). Culture is also a crucial factor that may influence the mental health of a population, such as the growing evidence-base showing the effects of culture on psychiatric manifestations, diagnoses and treatment (Chang and Kwon, 2014). Culture can shape expression and elicitation of clinical symptoms, illness models and treatment-seeking behaviours manifested through individual values (Lewis-Fernandez et al., 2014). The sociocultural background influences a service user's perspectives, values, beliefs, and behaviours regarding health and wellbeing. These factors can give rise to variations in recognition of symptoms, thresholds for seeking care, comprehension of management strategies and expectations of care.

Misunderstandings between service users and health care providers can often reflect inherent differences in cultural values and expectations. These misunderstandings can lead to outcomes ranging from mild discomfort to a major lack of trust that damages the therapeutic relationship (Betancourt et al. 2016). The review findings suggest that one of the most important competencies is to have the ability to provide practical solutions for problems that can occur in cross-cultural mental health care, rather than attempt to have an encyclopaedic knowledge of culture-specific responses.

Perspectives of health care providers in cross cultural mental health care

It is known that cultural knowledge and practice influences perceptions towards illness and help-seeking behaviours. It is therefore important that culture is central to mental health training and education with the aim of bringing about insights from the fields of sociology, psychology and anthropology. (Kirmayer & Swartz, 2013). It is known that through culture, people can reshape psychopathology and provide uniqueness to symptom expression. Thus understanding how culture shapes explanatory models and reactions to mental illness can help overcome the mental-health-related stigma which has played an important role as a barrier to the development of and access to mental health services (Ando et al. 2013, Alarcon, 2009; Viswanath and Chaturvedi, 2012).

We know that people from different cultures who experience mental health problems are more vulnerable, because they are often stigmatized by those in society who are ignorant of cultural diferences (Corrigan et al. 2015, Hinshaw 2015, Richards et al. 2014; Stefanovics et al. 2016). An intolerant local culture, can influence the thoughts and attitudes toward those with mental illness (Richards et al. 2014, Stefanovics et al. 2016), and lead to internalized

beliefs that negatively impact on treatment seeking (Mackenzie et al. 2014) which is a significant risk in the recovery process (Oliveira et al. 2015). Unfortunately, mental health providers and the general public within a given culture or nation may share similar stigmatized or negative stereotypical attitudes toward people with mental illness thus perpetuating the barriers to care (Stefanovics et al. 2016).

The findings of this review further suggest that the negative perspectives of health care providers towards mental illness, are derived from specific values and beliefs, which can lead to poor care experiences. VBP therefore helps to expose and modify such attitudes and beliefs and support more sensitive clinical decision-making particularly where complex and sometimes conflicting values are at play (Petrova et al. 2006). By adopting a values-based philosophical focus, health care providers can help promote and support more humanistic perceptions and attitudes amongst the wider community.

A path-way to promote cross-cultural mental health care

Having reflected on the review findings, whilst based on a modest range of studies, we suggest the need for health care provider teams in the field of mental health, to acknowledge the increasing diversity in society, and adopt a care development pathway that puts cross-cultural awareness and tolerance at the forefront of their philosophy of care and practice. This care pathway, outlined below is a simple and usable tool for helping provider teams to recognise their role in promoting wider understanding of the complex interplay between culture and mental health expression whilst promoting cross-cultural competence amongst their staff.

- The first and perhaps obvious step is for health care provider teams to share a desire to promote cross-cultural care.
- This willingness is the core element of the process of promoting self-knowledge and self-awareness of one own culture and how it may limit understanding and sensitivity to other cultures.
- Health care provider teams should improve their cross-cultural awareness by seeking to answer the question *"am I or my team competent enough to determine the cultural needs of our service users"*.
- This question, through the process of reflection, helps raise individual awareness and sensitivity toward other cultures but also helps to identify the training needs of staff and teams.

- The next stage, through training and awareness raising, is to begin to notice and change attitudes and meanings that health care providers may attribute to different cultures, which can create barriers to care. The training can be delivered by individuals and teams representing different cultural groups
- Using evaluation and feedback on service user experience of care, the team can build awareness of the cultural profile of their population and further develop their cultural competency.
- Through ongoing sharing, the team broadens their understanding of the complex interplay between biological, psychological, social and cultural factors that contribute to Mental illness, which facilitates person-centred and integrated care.
- The team seeks external validation of the changes they have made and becomes a beacon of cross-cultural care

In summary, we believe this simple pathway has promising clinical implications for reducing risks arising from the lack of awareness of cultural needs and for enhancing positive attitudes toward the health and well-being of people with mental health problems. If used effectively the pathway facilitates full immersion in and reflection on what cultural differences mean, how they affect perception and belief and how care can be adapted to accommodate such cultural differences

CONCLUSION

This systematic review was conducted to consider the research evidence for cross-cultural mental health care and, despite the limited evidence, reveals some important implications for the clinical and educational practice. The evidence indicates how important it is for mental health care providers to understand the complex interplay between culture and mental health and to develop cultural awareness and sensitivity toward service users who have a different cultural background to their own. Whilst at one level this seems to be stating the obvious, there tends to be a ‘one size fits all’ approach to care delivery with little nuance to accommodate such differences. This may well be different in culturally diverse populations where the mental health team reflect that diversity, but with growing cultural variation across many parts of the world, there is a need for service providers to avoid the tendency toward cultural homogenisation of service delivery.

The evidence also suggests that education providers have a role in offering continuing education to support preparedness to meet the cultural beliefs and behaviours that may be unfamiliar to health care providers. Such approaches could involve representatives of different cultural groups providing opportunities to explore belief systems in order to support the development of greater cultural competence. Ultimately, however, it is up to health providers to develop interventions that reflect cultural sensitivity and awareness as well as engage in more open minded critical self-reflection and dialogue around cultural competence.

Limitations

There are some limitations to this study. First, the combination of qualitative and quantitative studies may limit the comparability between articles. Secondly, only studies published in English were retrieved and reviewed; however, we recognise there may be literature meeting our review criteria published in other languages. Thirdly, despite the wide scope of the review, there was a limited number of papers on which to assess the state of play in this important area of practice. Thus this systematic review can be viewed as an indication of what still remains to be done in the field. Despite the limitations we believe our study is the first to investigate the published papers related to cross-cultural mental health care.

Declaration of Conflicting Interests

The authors declared that they had no conflicts of interest with respect to their authorship or the publication of this article.

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