Addressing Cultural Mistrust: Strategies for Alliance Building

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Nhi-Ha T. Trinh, Chun-Yi Joey Cheung, Esther E. Velasquez, Kiara Alvarez, Christine Crawford, and Margarita Alegría

Introduction

Trust is a crucial element in the provider–patient relationship and is key in developing a strong therapeutic alliance [1]. Discriminatory treatment of racial minorities, specifically African Americans, in mental health care has been well documented across the years, leading to cultural mistrust [2]. The historical underpinnings of racism have developed into a climate of cultural mistrust in the medical field and are reflected by

N.-H. T. Trinh (✉)
Psychiatry Center for Diversity, Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA

Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA
e-mail: ntrinh@partners.org

C.-Y. J. Cheung
Depression Clinical and Research Program, Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA
e-mail: jcycheung@outlook.com

E. E. Velasquez · K. Alvarez
Disparities Research Unit, Department of Medicine, Massachusetts General Hospital and Harvard Medical School, Boston, MA, USA
e-mail: evelasquez@mail.harvard.edu; kalvarez2@mgh.harvard.edu

C. Crawford
Division of Child and Adolescent Psychiatry, Department of Psychiatry, Massachusetts General Hospital, Boston, MA, USA
e-mail: Christine.crawford@mgh.harvard.edu

M. Alegría
Disparities Research Unit, Department of Medicine, Massachusetts General Hospital and Harvard Medical School, Boston, MA, USA

Department of Psychiatry, Harvard Medical School, Boston, MA, USA
e-mail: malegria@mgh.harvard.edu

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the underutilization of mental health care by racial and ethnic minorities. Indeed, mistrust has been shown to be a major barrier to people of color seeking mental health care [3]. These long-standing practices as part of America's past have resulted in the current set of beliefs surrounding health care–seeking behaviors and attitudes.

Historical Context of Cultural Mistrust

The history of cultural mistrust in the United States of America (USA) is rooted in political and social events that leading to systematic and differential treatment of individuals on the basis of their racial–ethnic identities. America's marred history has influenced the trust that individuals from a diverse set of ethnic and racial backgrounds feel toward the country's institutions. The comments below detail key examples for each racial and ethnic minority group, which have influenced these communities historically.

For African Americans, much cultural mistrust in the Western medical system stems from slavery. With limited resources and significant barriers to personal freedom, many slaves were not offered the opportunity to see health care providers and had to rely on alternative remedies from their African ancestry to cure their ailments [4]. African Americans were often denied treatments for medical issues and had to endure agonizingly painful deaths as a result [5]. During this period, slaves and "black bodies" were used as a prime source for medical experimentation and dissections. These human experiments were conducted to build the foundation of the Western medical model [6]. As slavery was abolished and African Americans were expected to assimilate into white culture, they were introduced to an American biomedical model that was not only drastically different from their familiar treatments, but also characterized them as a "lower order of human beings" [7].

Medical experimentation on black bodies beyond slavery serves as a poignant example. The most notable and notorious episode was the Tuskegee syphilis study, conducted from 1932 to 1972 by the US Public Health Department, in which researchers observed approximately 400 African-American males with syphilis to examine how the disease progressed without treatment, even after penicillin became a standard cure for the disease [8]. This case of blatant disregard for black lives and governmental racism in the twentieth century has been cited by many African Americans as the symbol and the quintessential example of their mistreatment by the scientific–medical communities [9]. African Americans encountered a Western medical system that did not understand, and did not seek to understand, the culture and mentality of their population. As a result, given the unconscionable withholding of treatment in the Tuskegee syphilis study, African Americans continue to distrust their physicians for not treating them equitably because of their race [7, 10].

For Asian Americans, the expulsion, segregation, and incarceration of thousands of Japanese Americans after the Pacific War is one of many significant examples of how Asian Americans were exploited in American history. While most of these individuals were American citizens, Japanese internment was a tragic mistake that was based on prejudice and wartime panic. Without any evidence or review process, this stereotyping led to unjust mass evacuations of approximately 100,000 people of Japanese birth or ancestry living on the West Coast of the USA [11]. Unfortunately, these prejudicial

attitudes toward Japanese were shared by the population at large, as shown by public opinion polls supporting these discriminatory actions against people of Japanese descent. The internment of Japanese Americans after the Pacific War was embedded in a history of discrimination against Asian Americans. While documented events of lynching, mass murders, and legislation banning migration of people from Asia have ceased, anti-Asian attitudes have not necessarily diminished over the years [12].

A history of racism has also greatly impacted Latino American health; conquest and colonialism in Latin America established a racial hierarchy, whereby people with any indigenous ancestry or of African descent occupied the lowest social castes, while people of Spaniard/European descent occupied the highest social castes [13]. For Latinos living in the USA today, this racial hierarchy has been reaffirmed by racial attitudes toward African Americans, resulting in greater social privilege and protection from discrimination among white Latinos than among darker-skinned Latinos [13]. Darker-skinned Latino immigrants report greater experiences of discrimination than their lighter-skinned counterparts [14]. The health disparity between light-skinned and dark-skinned Latinos parallels that between non-Latino whites and blacks [15]. These health disparities may continue to persist as Latinos begin to immigrate to new urban centers, which are often residentially and socially segregated along racial lines [16].

While there has been little research on medical mistrust among Latinos, related research has shown that Latinos may be less satisfied with their health care because of perceived racism and discrimination, as well as medical mistrust [17]. Recently, increasingly exclusionary immigration policies to curb illegal immigration from Latin America have also created a climate of stress and apprehension among Latinos, resulting in worse mental health among Latinos residing in states with more exclusionary policies [18]. Immigration policies can in fact influence Latino health through multiple pathways, including persistent stress from structural racism, as well as restriction of access to social institutions, education, and health care services [19].

For Native Americans, there is a 500-year history of systematic racism, exemplified by attempted genocide, broken treaties, and forced westernization of youth [20, 21]. Early on, as Native Americans succumbed to diseases brought by white settlers, the white settlers used these apparent health disparities in survival to validate their manifesto to claim North America and indoctrinate Native Americans with European culture, thus establishing a hierarchy between themselves and the Native American population [22]. However, there is evidence that the racism that motivated North Americans to view Native Americans as inferior was rooted in the desire to take tribal lands and resources and assimilate them into American culture [23]. From the allotment of separate lands to sequester tribes, to the boarding schools that separated Native American children from their parents, there has been a long history of oppression. Even today, there continue to be efforts to curtail tribal sovereignty, prolong assimilation policies of the nineteenth century, and retain management of Native American assets by the federal government [24]. The underlying theme is one of labeling Native Americans as inferior to limit tribal independence and their rights as citizens (i.e., being able to mortgage their lands, or economic developments in tribal lands being subject to review and control by federal agencies).

Present-day health disparities among Native Americans can be linked to historical trauma, which continues to affect communities cross-generationally [25]. Subjugation

by European settlers has led to centuries-long distrust and skepticism among Native American populations toward government and public institutions, as well as health care practitioners [20]. The systematic racism has been perpetuated in health care, where Native Americans maintain some of the highest morbidity and mortality rates but remain one of the most underserved communities [21]. Historically, the Indian Health Services (IHS) has been significantly underfunded in comparison with other public health care systems [26]. These health disparities emerged from the beginning of colonization, with Native Americans experiencing greater mortality from disease (tuberculosis, alcoholism, and chronic diseases) than whites during any decade [22]. Skepticism toward certain health care practices, such as in behavioral health care, may in fact result from divergent cultural views of health and health care between Native Americans and practitioners of Western medicine [20, 26]. Acknowledging historical trauma by incorporating cultural practices into clinical care is considered one method to improve behavioral health treatment and subsequently reduce health disparities among American Indian populations [27].

The latest victims of racism have been the Muslim community, with the January 2017 executive order banning entry to the USA by nationals of Iran, Iraq, Libya, Somalia, Sudan, Syria, and Yemen. The rationale for the order was to protect the American people from terrorist attacks by foreign nationals admitted to the USA [28]. This also includes restrictions in the visa waiver program, voted on by Congress in 2016, allowing people from 38 countries to enter the USA with no visa whatsoever [29]. There are several reasons why these bans can be seen as coming from a source of deep prejudice. First, as Greg Myre, the international editor of NPR News emphasized: "This executive order does not include any countries from which radicalized Muslims have actually killed Americans in the U.S. since Sept. 11, 2001." Second, even people traveling with valid visas have not been allowed to enter the USA after the ban, or were detained at airports and sent back to their countries, without any evidence of wrongdoing. This order not only has harmed many families coming to the USA for medical services but also has been damaging for foreign-born practicing physicians and international medical graduates who are trained in the USA [30]. Furthermore, Islamophobia can negatively influence health by disrupting several systems: individual (stress reactivity and identity concealment), interpersonal (social relationships and socialization processes), and structural (institutional policies and media coverage) systems [31].

As can be seen from these selected examples, a deeply ingrained historical context exists for racial and ethnic minority populations to harbor mistrust of the dominant institutions in the USA, which then translates into cultural mistrust in institutions of mental health care.

Definition and Context of Cultural Mistrust

The term "cultural mistrust" was initially defined by Tyrell and Tyrell [32] as a "tendency to distrust whites based upon a legacy of direct or vicarious exposure to racism or unfair treatment" and may provide an explanation as to why these patterns

persist. Cultural mistrust has been found to affect processes and outcomes of treatment specifically in the therapeutic alliance, which is defined as the active and conscious collaboration between a patient and a therapist. Therapeutic alliance outcomes affected by cultural mistrust include the depth of disclosures to and duration of treatment with white providers as compared with nonwhite providers [33, 34]. Even in efforts to define cultural mistrust, issues have emerged surrounding the terminology. In earlier efforts to describe this phenomenon, Grier and Cobbs [35] cited "cultural paranoia" to describe behaviors of African Americans in relation to their skepticism toward white providers. However, the term "paranoia" is coated with pathological connotations and suggests that the disbelief held by African Americans is unfounded. Therefore, that term has been vastly rejected [36]. Arguably, African-American distrust of whites is not a delusion but, rather, a manifestation of acquired experiences of facing greater discrimination than their other racial counterparts [37]. Cultural mistrust is therefore more likely linked to a history of racism and oppression of people of color by whites, which has led to the development of generalized suspicion [38]. However, this is not to imply that the said mistrust is acquired only through previous experiences; rather, it is also integrated as part of current experiences and is emboldened by constant microaggressions, mistreatment, and implicit biases [33, 39].

Current mistrust of the health care system by people of color is, without a doubt, due to a plethora of reasons. Racism in medical care cuts across genders, generations, and ethnic groups, leading to high levels of disdain toward the medical establishment [40]. As a trickle-down effect of the complex history that people of color have had with the medical system, nonwhite individuals have developed mistrust of many structural and institutional elements in the health care system. Today, more commonly, racism in mental health care is reflected by minority–white disparities in access to treatment and perceived biases [41–43]. Health care providers remain predominately white and have not properly addressed the trust dilemmas that unfold when there are cultural barriers between clients and providers [44]. Studies have shown that many people of color feel as if they cannot communicate with their provider if their provider is white. For example, they report feeling disrespected by their providers, feeling that they are unable to ask questions, and feeling as if the provider is not listening to them [45–47]. This level of skepticism has led many ethnic minorities to withdraw or withhold from treatment-seeking behaviors in order to avoid judgment. This issue is reviewed in detail in the next section.

Cultural Barriers to Mental Health Utilization, Based on Cultural Mistrust

The 2001 Surgeon General's *Culture, Race, and Ethnicity* report supplement [3] documented the existence of striking disparities for minorities in mental health services. In sum, the report found that racial and ethnic minorities have reduced access to mental health services in comparison with whites, are less likely to receive needed care, and when they do receive care, it is more likely to be poor in quality.

The supplement suggested multiple reasons for these disparities at different levels—structural, institutional, and individual—including the potential for patient mistrust and provider bias. With increased interest in understanding causes of racial and ethnic disparities in psychiatric care, there has been an increase in articles discussing cultural mistrust and an increase in measurement tools to assess the construct. This body of literature is summarized here.

Racial and Ethnic Disparities in Utilization of Psychiatric Services

Racial and ethnic disparities have been repeatedly demonstrated in utilization of psychiatric services. In studies using nationally representative samples of noninstitutionalized adults, whites have tended to be more likely to access mental health treatment than nonwhites [3, 48]. When utilization of specific psychiatric services is compared between nonwhites and whites, there appear to be disparities in psychotherapy, outpatient services, and psychotropic medication, but no such disparities exist in inpatient care. For outpatient psychiatric services, whites with mental illness have been shown to have greater odds of use than blacks (odds ratio [OR] 0.5, 95% confidence interval [CI] 0.39–0.55), Native Americans/Alaska Natives (OR 0.5, 95% CI 0.27–0.72), Asians (OR 0.4, 95% CI 0.32–0.60), and Latinos (OR 0.6, 95% CI 0.49–0.69) [49]. Similarly, in comparison with non-Latino white patients, Latino patients have been found to have ~37 fewer per 1000 office visits that included psychotherapy and 58 fewer per 1000 visits with a psychiatrist; these disparities have persisted over time [50].

Similar disparities are seen in psychopharmacology treatment. Blacks and Latinos are less likely to be prescribed an antidepressant than whites in ambulatory settings, and there has been no change in this disparity from the mid-1990s to now [50, 51]. Similarly, Latinos have been less likely than non-Latinos to be prescribed benzodiazepines during ambulatory visits; this disparity persisted from the mid-1990s through the early 2000s [51]. Blacks, Native Americans/Pacific Islanders, Asians, and Latinos with mental illness were less likely than whites to use psychotropic medications (OR 0.27, 95% CI 0.22–0.31; OR 0.19, 95% CI 0.08–0.48; OR 0.24, 95% CI 0.17–0.33; and OR 0.41, 95% CI 0.34–0.49, respectively). In another study of treatment of children with attention deficit hyperactivity disorder (ADHD), black and Latino children in the fifth grade with an ADHD diagnosis or symptoms were less likely than white children to receive medications (OR 0.33, 95% CI 0.17–0.62; and OR 0.38, 95% CI 0.16–0.90, respectively). This disparity persisted through tenth grade (OR 0.41, 95% CI 0.22–0.75; and OR 0.42, CI 0.20–0.86, respectively).

Although these studies regarding racial disparities in psychiatric services are compelling, most studies present only absolute disparity (relative to standards of care) or relative disparity (service use in comparison with the white population) but not both, making it difficult to fully understand the policy and clinical practice implications of the findings. Furthermore, additional research is needed to identify specific types of care within psychiatric services for which no disparity exists

(e.g., inpatient care) and for which whites receive less care (e.g., in public mental health care settings or addiction services) [50]. Finally, common approaches to the statistical models used in this body of research fail to disentangle the impacts of socioeconomic status, physical health, and race/ethnicity. One proposed solution has been to create hypothetical racial-ethnic groups that retain their racial-ethnic and socioeconomic characteristics, but whose mental health status is standardized to reflect a referent group, generally whites [49, 50]. This approach eliminates the possibility that findings are attributable to differential disease distributions among racial-ethnic group populations. It simultaneously allows the researcher to assess the impact of racial-ethnic group on psychiatric service utilization mediated by socioeconomic characteristics. Nevertheless, despite these limitations, these studies illustrate the profound impact of disparities in psychiatric services, which are influenced by issues of patient cultural mistrust of providers. How disparities are influenced by cultural mistrust is explored in the next section.

Provider Behavior, Racial and Ethnic Disparities, and Cultural Mistrust

Health provider behaviors help explain variations in psychiatric utilization across racial-ethnic groups and may also influence patient cultural mistrust of their providers. In a study of provider recommendations for treatment, although racial-ethnic minorities were equally likely to receive a recommendation from their provider to receive treatment, blacks were less likely than whites to receive antidepressant medication (OR 0.56, 95% CI 0.36–0.87) and Latinos were less likely to receive specialty mental health care or antidepressant medication (OR 0.30, 95% CI 0.22–0.44) [51]. These findings provide some evidence that disparities may persist even when provider recommendations for treatment do not. As a result, people of different racial–ethnic backgrounds have reported being less satisfied than whites with their health care providers, which in turn can have an effect on their health outcomes and desire to seek treatment [52].

Assessing Cultural Mistrust

Racial-ethnic disparities in psychiatric service utilization may be partially attributable to patient characteristics or to provider characteristics, as discussed above. Another possible causal mechanism of the disparity is the interaction of patients and providers and the patient–provider relationship, including trust and, more specifically, cultural mistrust [52].

The Cultural Mistrust Inventory (CMI), developed by Francis Terrell and Sandra Terrell [32], is a primary measure of cultural mistrust of whites. The measure has 48 items and a seven-point Likert response format, in which 1 indicates “strongly disagree” and 7 indicates “strongly agree.” Higher scores indicate a higher level of

mistrust. Terrell and Terrell developed the measure to provide a means of empirically testing the impact of cultural mistrust on outcomes across various settings, including mental health outcomes. There are four subscales of the CMI, which correspond to domains in which cultural mistrust of whites may exist: business and work, education and training, interpersonal and social settings, and law and politics.

Many measures have also been developed to evaluate trust and mistrust specifically in relation to the health system and health care providers [53]. Examples of such measures include the Trust in Physician Scale [54, 55], Medical Mistrust Index [56], Health Care Relationship Trust Scale [57], Group-Based Medical Mistrust Scale [58], Interpersonal Physician Trust Scale [59], Patient Trust Scale [60], Patient Trust in their Physician Scale [61], and Trust in Medical Researchers Scale [62]. Unlike the CMI, these measures do not assess trust/mistrust of whites and, by design, the domain in which trust is being assessed is specific to the health care context. Some of these measures have been used to assess trust/mistrust of health care providers among racial–ethnic minority groups [60–63]. However, there is little research that assesses trust/mistrust in the context of psychiatric care, and even less research that assesses racial–ethnic differences in trust/mistrust in the context of psychiatric care.

Empirical Use of the Cultural Mistrust Inventory

Whaley [64] conducted a meta-analysis evaluating the effects of cultural mistrust on multiple domains in 18 published and four unpublished studies from 1981 to 1998. Researchers across the 22 studies that were included in the analysis used the CMI in a variety of domains, including psychotherapy, intelligence quotient testing, mentoring, career aspirations, mental illness, social networking, and acquired immunodeficiency syndrome (AIDS) knowledge. The size of the effect of cultural mistrust on the outcome varied across the studies, but this variation was not statistically significant (X^2 =21.59, $p > 0.10$). Additionally, the effect sizes among the studies examining the mental health context did not differ from those in studies in other domains.

In the past decade, there has been continued research evaluating the effect of cultural mistrust within the mental health context. One vein of this literature explores the impact of cultural mistrust on mental health treatment preferences. In a study of 168 black adults with no prior experience with mental health counseling, higher levels of cultural mistrust, measured using a ten-item Modified Counselor Preference Scale [65], predicted a stronger preference for a black mental health counselor. David [66] examined the impact of cultural mistrust among Filipino Americans (n = 118) on treatment-seeking behaviors in a mental health service and found that higher levels of cultural mistrust were associated with lower levels of treatment seeking. David [66] used hierarchical regression modeling to demonstrate that the impact of cultural mistrust was not attributable to generational status, income, loss of face, or Asian cultural values.

Another aspect of the literature aims to explain variations in cultural mistrust. In their work with 74 young adult black males transitioning from the foster system, Scott et al. [67] found that an increase in negative social contextual experiences was associated with an increase in cultural mistrust of mental health professionals. Negative social contextual experiences were defined as negative experiences attributable to the individual's characteristics, being a member of the black community, or negative imagery projected onto black males (e.g., assumptions that they are engaged in illegal activity). In a study with a focus similar to the *negative social contextual experiences* construct, researchers Kim, Kendall, and Cheon [68] studied racial microaggressions and the impact of cultural mistrust as a mediator between racial microaggressions and well-being (as measured using the Attitudes Toward Seeking Professional Psychological Help—Short Form scale) [69]. Among their sample of 156 Asian American college students, an increase in microaggressions was associated with an increase in cultural mistrust and ultimately reduced well-being.

Taken together, the literature offers a narrative that begins to explain how the historical social context of racial-ethnic minorities in the USA influences cultural mistrust.

Approaches to Bridging Cultural Mistrust

The following section reviews the theory and evidence for approaches to bridging cultural mistrust in the therapeutic encounter, including racial matching, language matching, a focus on cultural competence, language concordance, and use of the Outline for Cultural Formulation and Cultural Formulation Interview in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5).

Racial or Ethnic Matching to Bridge Cultural Mistrust

Matching patients with providers of their own race or ethnicity is a commonly cited approach that may address barriers resulting from cultural mistrust. In a meta-analysis of racial–ethnic matching between therapists and patients, Cabral and Smith [70] focused on three variables: patient preference for a therapist of their own race/ethnicity, patient perceptions of therapists in a racial–ethnic match, and therapeutic outcomes in a racial–ethnic match. Patients across studies showed a relatively strong preference for therapists of their own race/ethnicity and a moderate tendency to perceive therapists of their own race/ethnicity positively, but there was nearly no effect of racial–ethnic matching on treatment outcomes. Taken together, these results indicate that racial–ethnic matching may be beneficial in engaging patients in therapy but has little impact on the effects of therapy in the long run. However, the authors cautioned that the overall results masked a great deal of variability across studies. The largest effect sizes across all three outcome variables were found for African-American participants, suggesting that racial–ethnic matching may impact minority groups differentially.

Good and Hannah [71] described a case process study of an inpatient psychiatric unit in which racial matching was deliberately, if unofficially, practiced with African-American patients. They reported that nonblack mental health associates (MHAs) matched black patients with black MHAs when they perceived potential conflicts for the patient in working with white staff. However, the effects of the matching were rooted neither in cultural similarity (the MHAs were described as African and the patients as African American) nor in greater empathy or understanding (the African MHAs were described as holding negative stereotypes about their African-American patients).

In an observational study of Latino patients, communication patterns among racially/ethnically concordant and discordant patient–clinician dyads suggested that communication patterns may explain the role of ethnic concordance in continuance in care. Latino concordant dyad patients were more verbally dominant ($p < 0.05$), engaged in more patient-centered communication ($p < 0.05$), and scored more highly on a working alliance bond scale (all $p < 0.05$) than other groups [72]. When in an ethnically concordant dyad, Latino patients have better outcomes as compared to other racial-ethnic groups in concordant dyads. When adjusting for non-communication variables, Latinos in both ethnically concordant or discordant dyads had higher rates of continuance. However, when adjusting for communication, global affect, and therapeutic process variables, whites in either type of dyad had higher rates of continuance than other racial or ethnic groups. This description raises questions about what constitutes a racial–ethnic match, and in what circumstances it may be effective for patients. However, given the small numbers of racial–ethnic minority behavioral health providers relative to the proportions of those groups in the general population, this approach is not feasible in many mental health care settings [44]. On the other hand, approaches that promote a therapeutic alliance across racial, ethnic, and cultural differences between the patient and the provider will be applicable in a wider range of settings but can be difficult to operationalize and implement [74].

Language Matching to Bridge Cultural Mistrust

Another type of matching, by language, may impact the therapeutic alliance and outcomes for non-English-speaking racial–ethnic minorities; however, in many settings, interpreters will be needed to ensure communication between patients with limited English proficiency and English-speaking providers. A large study of Chinese and Vietnamese immigrant adults receiving care in community health centers found that those who used interpreters were more likely to have questions about their care and about mental health than those who were language concordant with their providers, yet the two groups did not differ on other communication measures or in their likelihood of reporting receipt of high-quality care [73]. Those who rated their interpreters highly were also more likely to rate the quality of care they received highly.

In a study of service outcomes of adequacy of care, emergency room (ER) care, and inpatient care among Portuguese-speaking patients in ethnic-specific and non-ethnic-specific behavioral health clinics, those patients receiving care in culturally

and linguistically competent mental health care settings were more likely to receive adequate care than those receiving usual mental health care [74]. The findings suggested an increased quality of care for patients who have contact with a clinic that dedicates resources specifically to a minority/immigrant group.

In a mixed-methods study on the effects of interpreter use in behavioral health encounters for Spanish-speaking patients, no differences in the therapeutic alliance were found for clients who used interpreters versus those who did not [75]. Qualitative interviews revealed a more nuanced perspective, with patients reporting a preference for bilingual providers, while appreciating the access to services provided by interpreters. In ensuring language access through either bilingual providers or trained interpreters, systems must invest in the availability of services and allow the time needed to utilize interpreters [76]. Individual providers must then use the services available, rather than relying on ad hoc interpretation from family members or untrained colleagues, as ad hoc interpretation has its risks from a quality-of-care standpoint [76]. In a literature review examining the effects of patients' limited English proficiency and use of professional and ad hoc interpreters on the quality of psychiatric care, Bauer and Alegría [77] found that the quality of care can be compromised when patients are evaluated in a nonprimary language or when an interpreter is used; evaluation in a patient's nonprimary language can lead to incomplete or distorted mental status assessment [78]. Although both untrained and trained interpreters may make errors, untrained interpreters' errors may have a greater clinical impact, compromising diagnostic accuracy and clinicians' detection of disordered thought or delusional content. Use of professional interpreters may also improve disclosure in patient–provider communications, referral to specialty care, and patient satisfaction.

Cultural Competence to Reduce Cultural Mistrust

In studies of medical students and primary care residents, only 20% of medical students reported being well-prepared to care for patients with low English proficiency, while primary care residents' self-report of preparedness to deliver cross-cultural care was based on the amount of instruction that physicians received to deliver such care, underscoring the importance of formal education [79, 80]. The majority of therapists—from 72% to 91% across five studies—self-reported being culturally competent in their work with racial–ethnic minority clients [81]. In a survey of 689 psychologists, the majority of whom were white, more than 80% reported discussing racial–ethnic differences in at least one cross-racial therapeutic encounter within the previous 2 years [82]. Yet, the psychologists surveyed also reported that racial–ethnic differences were discussed in fewer than half of all cross-racial encounters. Little research has directly assessed culturally competent practice in clinical encounters, leading to uncertainty as to whether these self-ratings reflect actual practice, and whether the practices that are taking place have any effect on client outcomes [83]. Given that unintentional bias by providers may have a strong effect on the therapeutic relationship, it is critical to measure aspects of the

therapist–client relationship that may not be recognized by the therapists themselves [83].

Cultural competence encompasses systems as well as individual therapeutic encounters. Betancourt and colleagues [84] define three levels of cultural competence interventions: organizational, structural, and clinical. They note that at the clinical level, training has often focused on a categorical approach that involves ascribing attitudes, values, beliefs, and behaviors to broad cultural groups—which may lead to stereotyping. Combining knowledge-based training with process-based training in cross-cultural communication allows for more nuanced understanding of how cultural content may or may not be relevant to individual clients [84]. There is some evidence that cultural competence training can lead to increased knowledge and awareness among providers, but it is unclear whether training also improves client outcomes [85, 86].

Cultural competence is not uniformly accepted as a core competence in therapy. Sue [87] summarizes the debate on the utility of cultural competence through a series of questions. These include whether cultural competence stereotypes minority clients, discriminates against other types of diverse identities such as social class or sexual orientation, overemphasizes external factors such as discrimination at the expense of intrapsychic factors, and creates pressure to subscribe to cultural competence in order to be viewed as nonracist. The authors respond to these debates by noting that they tend to oversimplify the concept of cultural competence and ignore a more nuanced perspective—which includes a focus on multiple intersecting identities and an acknowledgment of intrapersonal, interpersonal, and societal influences on the lives of clients. Ultimately, the authors argue that cultural competence is necessary as a response to a historical context that has resulted in systematic bias against the inclusion of culturally-specific experiences in therapy.

Qureshi and colleagues [88] note that the term "cultural competence" itself may obscure important distinctions in the types of barriers faced by racial–ethnic minority patients. A focus on culture may pertain to differences in understanding and expressing symptoms, as well as how preferences for treatment are developed and communicated. However, experiences of racial and ethnic discrimination or barriers presented by poverty, immigrant status, and other experiences linked to minority status are not "cultural" but, rather, structural challenges disproportionately experienced by members of nonwhite racial–ethnic groups [88]. Clinicians must therefore be prepared to address a wide range of possible experiences impacting their clients; however, many training models focus primarily on acquisition of knowledge, rather than on development of skills or examination of attitudes [88].

Cultural Tailoring to Reduce Cultural Mistrust

Huey and colleagues [81] found that psychotherapy is generally effective across racial–ethnic minority groups, and they reported robust effects across groups and psychiatric conditions. The evidence for the effectiveness of culturally tailored treatments was mixed, however, leading the authors to summarize several distinct

ways in which cultural tailoring may be more or less effective, including cultural tailoring for a specific ethnocultural group rather than a mixed one; matching of therapists with clients who speak their primary language; provision of tailored treatments for older, less acculturated clients; achievement of congruence in therapeutic goals between the therapist and the client; use of metaphors and symbols that match the client's worldview; adaptation of the clients' beliefs about the cause, course, and treatment of psychiatric illness; and implicit instead of explicit addressing of cultural factors.

Qualitative research can shed light on specific therapy processes valued by racially and ethnically diverse clients. In a study of 16 therapy dyads consisting of a white therapist and a racial–ethnic minority client, Chang and Berk [89] contrasted the experiences of those who were satisfied with therapy and those who were not. The characteristics reported by satisfied patients included an active rather than passive style, therapist self-disclosure, attentiveness, and a nonjudgmental and validating stance. Characteristics reported by dissatisfied patients included therapists' lack of culture-specific knowledge, lack of awareness of the dynamics of power and privilege, engagement in unprofessional behavior that made the client feel disrespected, and engagement in behaviors or nonverbal communication perceived as dismissive and invalidating. In their analysis, the authors noted the importance of negotiating and repairing ruptures in the therapeutic alliance and posited that attending to these ruptures is especially important in cross-racial therapy encounters. The authors also highlighted the importance of attending to individual differences, describing how some clients did not want issues of race/ethnicity to be central to their therapy experience and were sensitive to being treated differently because of race.

In a study of relational preferences among African-American, Latino, and white behavioral health patients with depression, all three groups endorsed similar themes (listening and understanding across all three groups, and spending time for Latino and white patients). However, the way in which these themes were defined differed across groups. For example, for the theme of understanding, African-American patients described it as understanding aspects of the patient that could not be seen on the surface, Latino patients described it as understanding the patient's feelings, and white patients described it as understanding the complexity of the patient's circumstances and choices [90]. These results highlight the importance of not only identifying patient values in the assessment process, but also operationalizing what those values mean to the individual and to the cultural group(s) with which the individual identifies.

Use of the DSM-5 Cultural Formulation Interview to Shape Clinical Practice

Cultural formulation interviews are intended to capture the patient's explanatory model of illness [91]. Efforts to operationalize a cultural formulation interview tool for psychiatric practice led first to the Outline for Cultural Formulation (OCF) in the

DSM-IV [92, 93]. Despite wide interest in and use of the OCF, substantial barriers to its adoption and implementation were also reported; these included the format being too vague and unstructured, and a lack of clarity about how the OCF fits into standard clinical practice [94]. More recently, the OCF was revised extensively into the Cultural Formulation Interview (CFI) in the DSM-5 [95]. The current CFI is a standardized, manualized interview based on 16 stem questions and probes, which was tested for feasibility, acceptability, and clinical utility in a DSM-5 field trial [91]. The areas addressed in the interview are the cultural definition of the problem, causes, stressors and supports, the role of cultural identity, self-coping, past help-seeking, barriers, preferences, and the clinician–patient relationship [95, 96]. Twelve supplementary modules for the CFI are also available to address specific groups (e.g., immigrants and refugees).

Qualitative interviews with patients and clinicians suggest that use of the CFI enhances rapport through satisfaction with the interview, elicits both information and perspectives from the patient, and facilitates perception of data at multiple levels of awareness. For some clinicians and patients, the CFI has also resulted in better provider communication of care and recognition of communication barriers [91]. Several aspects of the CFI could provide opportunities to address and ameliorate cultural mistrust; for example, several probes reference eliciting information on subjects such as discrimination, stressors related to one's background or identity, and barriers to accessing treatment in the social context. The final question in the interview addresses the clinician–patient relationship: "Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. Have you been concerned about this and is there anything that we can do to provide you with the care you need?" [95, 96]. However, this question was revised to put the focus primarily on the patient rather than on the provider, because of problems with clinician buy-in on a question that more directly addressed the provider's role in these interactions [94]. Others have noted that despite the presence of the CFI in the DSM-5, the overall manual still relies primarily on a conceptualization of mental health that is individually focused and not embedded in a social context that includes exacerbating factors such as racism and discrimination [97]. The CFI represents an important step forward in institutionalizing and standardizing the work of cultural psychiatrists, anthropologists, and others in a format accessible to all clinicians; however, the work of directly addressing cultural mistrust must be accomplished through work beyond the clinical interview.

Summary of Recommendations

This last section describes strategies on the individual clinical level, as well as systemic strategies for facilitating a positive alliance and reducing cultural mistrust that racial and ethnic minorities might feel when interacting with clinicians in mental health treatment.

Clinical Recommendations

Many health care providers are becoming increasingly aware of the need to develop skills to better address issues of cultural mistrust, yet they may lack the training to do so. Below are six recommendations to increase the capacity of mental health providers to address issues of cultural mistrust in their practice.

Providing Coaching to Mental Health Professionals

While coaching is currently available to mental health professionals, more specific training should be developed for them to effectively manage cultural mistrust and avoid (1) the cognitive shortcut of quickly making stereotypical assumptions or biased judgments of their minority patients; (2) seeing themselves as objective in their judgments of "others" when they really are not; (3) spending insufficient time in understanding the perspective of their patients; and (4) missing opportunities to connect with diverse patients when billing and medical compliance aspects override attempts to tailor the session to the needs of the patient. This might require training by cultural brokers and bringing in interpreters to at least provide a language match between the patient and the provider. In both of these circumstances, ensuring confidentiality is of paramount importance. One area to test is the idea of transnational treatment, meaning provision of some mental health care resources by people from the patient's own culture. This can be achieved through the use of telepsychiatry, which has shown promise in overcoming cultural barriers, improving patient satisfaction, and treating mental illness in racial–ethnic minorities [98–102]. One example of this approach is the DECIDE intervention by Alegría and colleagues [103], in which racial–ethnic minority patients were taught strategies to improve activation and self-management in the clinical encounter as a way to avoid the steep cultural divide between the provider and the patient.

Bolstering Opportunities to Understand Cultural Scripts

Training programs should educate mental health professionals on how to bolster opportunities that may help them better understand their patients' cultural scripts, those aspects that help patients make sense of their life circumstances, and the options that are available to them. This might require giving professionals the emotional bandwidth to practice collaborative mental health care by teaching them how to activate their patients as a way to empower them in treatment. It also might include coaching providers on how to discover with patients what they may see as acceptable options in their treatment. Because unintentional bias on the part of providers may have a strong effect on the therapeutic relationship, having providers audiotape their sessions, and having supervisors or colleagues evaluate them, can help obtain more objective feedback on the therapeutic alliance and on communication.

Bringing Hope and Humility to Providers

Mental health professionals should feel encouraged to maintain hope and humility in their clinical encounters with patients who feel cultural mistrust. With few

resources to manage their patients' vast needs, providers sometimes become pessimistic about their ability to work with or to inspire patients who seem resistant or hostile to treatment. However, hope from providers can aid patient recovery. Offering supportive supervision to mental health providers can decrease the likelihood of eroding their hope, cultural humility, and other attitudes that may dwindle patients' cultural mistrust.

Allowing Sufficient Time to Address Culture in Sessions

Time is often a limited resource in treatment. Therefore, it is key that mental health providers are given sufficient time to attentively listen and explore patient preferences and, particularly, to address past experiences that could reinforce patients' cultural mistrust. This might entail providers leaving behind their verbal dominance in the clinical encounter, practicing shared decision-making in treatment decisions, and being explicit about their understanding of patient directives for care. It might also imply utilizing cultural tailoring of the intervention to make sure its core elements resonate with the worldview of the patient. Having time to adapt manuals—but also sessions—to the patient's preferences, within guidelines, is also of paramount importance.

Reading, Learning, and Discussing Historical Contexts of Cultural Mistrust

As part of the curriculum, mental health providers should be required to read, learn, and discuss the historical contexts of cultural mistrust. More than matching providers in terms of racial or ethnic backgrounds, understanding historical contexts can help providers find matching social identities to those of their patients. The patient and provider may have common ground that can be used as a way to build a similar history and to establish some shared meanings. At the same time, the provider should acknowledge differences and discuss with patients potential ways in which they might need to provide expertise, so that the provider can understand how the historical context of mistrust might bleed into their own relationship.

Encouraging Patients to Describe Positive Experiences with Providers

Given that patients are experts in their own experiences, they should be encouraged to generate descriptions of instances that have previously helped build a relationship of respect, trust, and lack of judgment from their providers. This is crucial even when patients have initially experienced cultural mistrust toward their provider. If this is a new patient, the provider could assess past relationships that facilitated a climate of trust and respect in their past therapeutic relationships. These examples can be used as ways to ensure that the patient feels that these are important shared goals.

Systemic Strategies

For many mental health care providers, they might be one of the few institutional resources that patients can tap into to navigate complicated governmental systems to address their needs. However, for those who experience cultural mistrust, structural racism and discrimination within systems of care are a more common challenge to mental health access. Here are four recommendations to overcome racism within systems of care.

Assessing Discriminatory Policies Against Health Care Access

Institutions should assess whether there are policies that might discriminate or become obstacles for access to or receipt of quality care. For example, lack of linguistic competence in the professional workforce might seriously handicap the possibilities of offering minimally adequate care or in offering treatments. Community health workers trained in evidence-based treatments could, with professional supervision, help to fill this gap. For example, lack of addiction service groups for non-English-speaking patients might curtail their opportunities for recovery. One way to resolve this would be by offering higher payment for services offered in non-English languages.

Evaluating Patterns of Mental Health Care at Organizational Levels

A health care system should seek to understand how patterns of mental health care vary by race/ethnicity, gender, or method of payment. Once potential disparities are identified, efforts should be made to evaluate whether the differences are due to provider behavior, organizational behavior, or patient preferences. Such evaluation, for example, can be done by examining patient dropout rates by clinic, by provider, or by payment method. It is then important to ascertain whether patient no-show rates and lack of engagement converge across racial and ethnic groups. This information can be used to brainstorm and address potential mechanisms contributing to these patterns. In turn, insurance programs can be requested to offer bonuses for institutions that effectively reduce the disparities.

Coaching Administrators on Cultural Mistrust

Coaching administrators on cultural mistrust and on the historical context of cultural mistrust can encourage buy-in on the importance of eradicating institutional racism. It is important to assist leaders in being open to exploring instances of institutional racism, and how to address them. It should be assumed that everyone can benefit from coaching on these issues, with the potential to change attitudes and reduce harmful behaviors.

Recognizing and Incentivizing Leaders to Work Against Institutional Racism

Organizational leaders should be encouraged to recognize and address institutional racism, creating a cadre of champions to lead the organization by modeling equity as a salient institutional goal. Reinforcing this message in provider orientations and as part of continuing education is of paramount importance in the development of culturally competent leaders. Making institutional racism part of the indicators of quality required by forums such as the National Committee for Quality Assurance or the Joint Commission's Pioneers in Quality program would be one way to address the problem.

Conclusion

Issues of cultural mistrust in racial and ethnic minorities are rooted in the legacy of racism and inequity that has plagued the USA since its inception. This historical thread contributes to present-day disparities in the access to and quality of mental health care among racial minorities. However, with growing interest in the phenomenon of cultural mistrust, there is also increased recognition of the issues at stake in terms of structural factors influencing mental health outcomes. Strategies to bridge these gaps at both the individual and systemic levels provide hope for reducing cultural mistrust and eliminating racial disparities in mental health care.

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