# Culture and Depression: Clinical Considerations for Racial and Ethnic Minorities

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**Case Vignette**

*The daughter of a 55-year-old widowed self-identified Black woman calls her mother's primary care provider (PCP) office for help. Her mother has a history of sleeping more than usual, "not doing anything anymore…not even going to church," and will not make her bed or take a bath without prompting. Even though her mother's primary care physician has previously recommended a psychiatric consultation, her mother is reluctant to seek counseling because "I'm not crazy!" She will only go to clinic visits to her primary care physician's office with a ride from her daughter.*

*Although the nurse from the PCP's office encourages the daughter and the patient to come into the office, the daughter is unable to take time off of work to make an appointment during the workday. Over the next few weeks, however, the daughter calls her mother's PCP's office several times with similar concerns— her mother is not eating, caring for her activities of daily living, or going to church.*

*Finally, the mother becomes very disoriented, and she walks outside during the day in her nightgown and knocks on a neighbor's house confused, saying: "I think our house is on fire." The neighbor calls the daughter from work; the daughter takes off work urgently and brings her mother into the emergency department for urgent evaluation. The mother is hospitalized to the medical service for delirium secondary to dehydration and seen by the psychiatry consult/liaison service first for delirium, visual hallucinations, and "sundowning."*

*The geriatric psychiatrist on the service is a self-identified Black man whom the patient immediately takes to—"I've never been taken care of by such a handsome young physician before, even when I lived in the South!" Once the delirium has been stabilized, the inpatient medical team is concerned because the patient appears withdrawn, is not eating, nor is she able to sleep at night. Asking the patient about what she enjoys, the patient reveals that she loves going to church but has missed being able to do this because "I've been so weak and lonely." The psychiatrist is able to build rapport with the patient and her daughter because he knows the patient's community and church pastor.*

*Although the patient is very reluctant to start medications, the psychiatrist uses a symptom-focused approach and asks her what is currently troubling her. The patient reveals, "I've been so lonely at home." When she and her daughter confirm that the "not being able to sleep is the worst," and the daughter expresses fears that her mother is losing too much weight, the psychiatrist recommends a low dose of mirtazapine to help with those symptoms. With his guidance and patient's acceptance, the medical team starts mirtazapine 7.5 mg to help the patient with insomnia and appetite. After initiation of the medication over several days, the patient's sleep quality improves, as does her appetite.*

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*It is time for discharge, and inpatient team would like the patient to go to a rehabilitation facility prior to going home. The daughter is very upset about this plan, expressing concerns that she will have to put her mother in a long-term nursing home, since the daughter works full-time and has a young family. "My mother doesn't want that, and besides, those places aren't welcoming to folks like us." At the family meeting, the psychiatrist is able to talk with the family about their wishes to have the mother come home after a short stay in "rehab" (emphasizing the "short-term" nature of the stay), and case management is able to set up a day program at the community senior center affiliated with the patient's church community. The patient and family request to see the psychiatrist in his outpatient practice after the mother's discharge.*

## Introduction

Depression is a common mental health condition that leads to significant distress and impaired functioning. In fact, as of 2017, depression is the leading cause of disability worldwide [1–3]. In the United States, racial and ethnic minorities have increased from 19% to 27% of the population in the past 20 years [4, 5]. The US Census estimates that by 2044, the United States is projected to become a "majority minority" nation, with no race or ethnic group projected to have a greater than a 50% share of the nation's total population [6]. Given these demographic shifts, an increased focus is needed to understand the phenomenology and treatment of depression in racial and ethnic minority populations (including Black, Latino American, Native American, and Asian Americans). Though evidence-based interventions for treating depression are widely available, the condition is often undertreated among racial and ethnic minorities in particular. Indeed, significant disparities exist in the diagnosis and treatment of depression for these underserved groups as compared to whites [7, 8].

Disparities are defined as differences in healthcare services received by two groups that are not due to differences in underlying healthcare needs or preferences of members of the groups but rather due to the structure of the healthcare system, provider or patient biases, or clinical uncertainty [9]. The groundbreaking Surgeon General's Report [10] "Culture, Race, and Ethnicity" in 2001 implicated systemic, clinical, and individual patient factors contributing to disparities in mental health access to care for racial and ethnic minorities, as compared to white populations in the United States. In sum, the report found that racial and ethnic minorities are less likely to receive needed care, and when they do receive care, it is often found to be lacking in quality as compared to their white counterparts.

The supplement to this report suggested multiple reasons for these disparities at different levels, including financial-, structural-, and patient-level barriers [11]. Financial barriers are related to the inability of patients to access healthcare given their insurance status (due to being uninsured or underinsured). Structural factors refer to the overall system's availability to provide care, regardless of individual patient financial status, and can also include factors external to the process of seeking care, including availability and proximity of appropriate facilities for care in a geographical location. Finally, patient-level factors include patients' beliefs and/or knowledge about the healthcare system, as well as communication barriers, which can be influenced by patient personal biases or cultural differences [11]. Rather than working independently, these barriers may intersect, leading to racial and ethnic minorities not receiving adequate screening and care for depression, and thus present to treatment at a later stage of disorder. In 2006, the Federal Collaborative for Health Disparities Research (FCHDR) has listed mental health disparities as one of the top four priorities for immediate research attention, conveying the gravity of this problem [12].

In this chapter, we will review specific risk factors for depression in racial and ethnic minorities and explore the challenges of diagnosis and treatment for these underserved populations. Taking these challenges into account, we will provide treatment recommendations to consider when caring for these populations at risk.

## Historical Perspective: Depression and Minority Status

### Key Definitions: Race, Ethnicity, Culture, and Minority Status

Prior to starting a discussion of how the field of mental health research and practice has evolved, key concepts are reviewed here. *Race* is defined as a category of humankind that shares certain distinctive physical traits [13], such as skin color, facial features, and stature. Most people think of race in biological terms; for more than 300 years, or since the era of white European colonialization of populations of color in the world, race has indeed served as the "premier source of human identity" [14]. Anthropologists, sociologists, and many biologists now question the value of these categories and thus the value of race as a helpful biological concept [15, 16]. Indeed, DNA studies have debunked race as a biological construct and more of a social construct, as less than 0.1% of all our DNA accounts for physical differences among people associated with racial differences [17]. However, because society has valued these physical differences, the classifica-

tion of individuals based on physical characteristics has led societies to treat them differently—and unequally.

In contrast, *ethnicity* refers to a particular ethnic affiliation or group [18], with the term *ethnic* relating to large groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background ethnic minorities [19]. Thus, ethnic groups also are a social construct and have shared social, cultural, and historical experiences, stemming from common national or regional backgrounds.

The term *culture* has multiple meanings: culture can describe the beliefs, customs, arts, etc. of a particular society, group, place, or time; culture can be used as a synonym for a particular society that has its own beliefs, ways of life, art, etc.; finally culture can refer to a specific way of thinking, behaving, or working that exists in a place or organization [20]. Clearly certain ethnic or racial groups can have their own cultures, but the association is not always one to one, and groups or organizations made up of multiple races or ethnicities can create their own culture, such as, for example, "American culture" or the culture of medicine.

A *minority group* is a part of a population differing from others in some characteristics and often subjected to differential treatment [21]. Minority groups are differentiated from the social majority, defined as those who hold on to major positions of social power in a society. The differentiation can be based on one or more observable human characteristics, including ethnicity, race, religion, disability, gender, wealth, health, or sexual orientation, and may be enforced by law. Usage of the term is applied to various situations and civilizations within history despite its association with a numerical, statistical minority [22].

## Early Work on Race, Ethnicity, and Depression

Early research in depression risk did not focus on the connection of race and depression, but rather on the effects of social status on risk for developing psychological disorders [23, 24]. In the 1980s, the focus turned to disentangling the effects of race, ethnicity, and socioeconomic status with depressive symptoms, with the recognition that certain sociodemographic factors such as poverty have differentially affected racial and ethnic minorities, particularly Black populations in the United States, throughout its history [25]. Although early studies found that the prevalence of depressive symptoms generally did not differ between whites, Blacks, and Latinos (both English and Spanish speaking) [26, 27], Jones-Webb and Snowden [28] later demonstrated that Black populations had specific sociodemographic risk factors as compared to whites, putting this population at risk for developing depression. For both Black and white populations, female gender, separated or widowed marital status, lower social class, and lack of employment conferred increased risk for depression; however, the researchers found additional risk factors for the Black population in their sample: those who were 30–39 years of age, belonged to non-Western religious groups, and lived in the West were at greater risk for depression as comparable whites [28]. This finding has since been expanded for the Latino American population, as both Blacks and Latinos have been found to be at risk for developing depression due to having fewer economic resources and a lack of wealth in comparison to whites [29]. Indeed, current epidemiological surveys indicate that prevalence rates of depression can vary considerably among racial and ethnic minority populations, not only in the United States, but also in Europe [30]. Socioeconomic conditions and (unconscious and conscious) bias against racial and ethnic minority groups have consistently been found to be important predictors of these differences [31].

## Current Advances in Depression Research in Racial and Ethnic Minorities

Despite increased research on the mental health of racial and ethnic minority populations, disparities in diagnosis, treatment access, and outcomes continue to persist [32]. As defined above, a disparity is a difference in diagnosis, access to treatment, and treatment outcomes between two groups that is not based on clinical appropriateness and need. For example, researchers have found that minority populations generally utilize mental healthcare less than their white counterparts, even though they are more likely to have persistent mental disorders throughout their lifetime [33, 34]. In this section, we will explore potential causes for these disparities in mental health diagnosis, treatment, and outcomes in racial and ethnic minority populations.

## Challenges in Diagnosis of Depression in Racial and Ethnic Minorities

In order to receive any kind of mental health treatment or care, the first step for many racial and ethnic minorities is to see their primary care clinician for evaluation and to receive a correct diagnosis. However, the presentation of depression symptoms may be different for racial and ethnic minority groups compared to whites. This may be partly due to their cultural or ethnic backgrounds, but also the structure of the healthcare system they seek help in, and their past exposure of the meaning of having depression through media and interpersonal interactions [35].

Racial and ethnic minorities with depression may present more often with symptoms of insomnia and feelings of restlessness [36], increased distress and somatic symptoms [10, 37],

and increased cognitive impairment [38], in comparison to whites. Clinicians who search only for physiologic explanations for somatic complaints such as back pain, tinnitus, headaches, palpitations, and dizziness may miss depression or anxiety as the cause. Because clinicians may not be aware of these differences in symptom presentation, decreased detection of these symptoms often results in the underdiagnosis or misdiagnosis of depression in these populations [39]. Inaccurate initial diagnoses result in delays in treatment or suboptimal treatment, which may lead to a prolonged course of depression.

Recent reviews have explored racial disparities in the diagnosis of depression. Simpson and colleagues [40] reviewed four empirical articles from a combined representative sample of over 75,000 participants in the United States. They assert that two out of the four articles reported significantly lower diagnostic rates for depression in both Blacks and Latinos as compared to whites. Furthermore, in the National Ambulatory Medical Care Study of over 96,000 patients, Stockdale and colleagues [41] found that in both psychiatric and primary care settings, both Black and Latino patients were less likely to be diagnosed with depression or anxiety, and thus less likely to receive subsequent treatment, as compared to whites. Additionally, researchers have also found that even when there is equal reporting of symptoms, primary care physicians are still less likely to detect depression in racial and ethnic minorities as compared to whites [39]. Finally, Coleman and colleagues [42] found that across 11 nationwide large not-for-profit healthcare systems, all racial and ethnic minority groups (Asian American, Native Hawaiian/Pacific Islander, Blacks, and Latino Americans) were less likely to be diagnosed with depression as compared to whites. This pattern of underdiagnosis of depression in racial and ethnic minorities is then compounded by barriers to treatment access for depression, which is discussed in more detail below.

## Challenges with Access to Treatment

As outlined previously, there are many barriers that exist in treatment access, including financial-, structural-, and patient-level barriers, preventing racial and ethnic minorities with depression from seeking and receiving quality care [43]. For example, research has shown that Blacks, Latino Americans, and Asian Americans are all less likely to seek treatment for depression in comparison to whites [42, 44, 45]. In addition, even after adjusting for factors such as poverty, insurance, and education, race still plays an independent role in limiting access to treatment for depression [42, 44, 45].

### Financial Barriers

Financial barriers are related to the inability of patients to access healthcare given their insurance status due to being uninsured or underinsured. In addition, in racial and ethnic minority populations, there are higher rates of poverty and less complete health insurance coverage as compared to non-Latino whites [44]. This trend in insurance coverage continues in spite of recent efforts by the Affordable Care Act in 2010 to expand insurance coverage and mandate coverage for mental health services for all [32, 46].

### Structural Barriers

Structural barriers refer to factors that limit the overall availability and accessibility of the healthcare system to patients and can include factors relating to the process of seeking care, as well as the characteristics of the healthcare system and providers themselves [11]. In other words, structural barriers to care are based on the healthcare system's specific policies, institutions, and internal belief systems including how our society's unconscious and conscious biases regarding race may influence a healthcare system's organization and attitudes [47]. In a review conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) [32], researchers proposed that limited mental health referrals were important structural barriers for a lack of access to mental health treatment for racial and ethnic minorities. As compared to whites, racial and ethnic minorities who endorse depressive symptoms may be less likely to be referred for appropriate counseling by their primary care providers. Similarly, Stockdale et al. [41] found that both Blacks and Latinos were less likely to receive referrals for counseling in both primary care and psychiatric settings as compared to white populations. This issue is significant, particularly in primary care settings, because racial and ethnic minorities are more likely to seek mental health treatment from their primary care physicians than other settings [32, 46].

The lack of availability of language capacity for non-English speakers is also a structural barrier. This illustrates a lack of capacity of healthcare institutions to provide services for the populations for which they are responsible. In a study of white, Black, Asian, and Latino populations, among subjects who spoke no English and specified a need for mental healthcare, only 8% of them actually received such care, versus 51% of subjects who spoke English only and 42% of subjects who were bilingual [48].

Furthermore, physician biases also play a role, not only in underdiagnosis of depression, but also in undertreatment. Racial and ethnic minorities who do receive care are less likely to receive antidepressants for depression diagnosis as compared to whites. Simpson et al. [40] found that Blacks and Latinos were less likely than whites to receive antidepressant treatment for depression. In addition, while both groups were less likely to receive antidepressants, Blacks were the least likely, in comparison to Latinos, to receive them [40].

These structural barriers, including the lack of referrals and adequate treatment, exist for racial and ethnic minorities then lead to *structural vulnerability* in these populations, defined as "an individual's or a population group's condition of being at risk for negative health outcomes through their interface with socioeconomic, political, and cultural/normative hierarchies" [49, 50]. Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies (e.g., socioeconomic, racial, cultural) and institutional and policy-level statuses (e.g., immigration status, labor force participation) constrain their ability to access healthcare and pursue healthy lifestyles [47]. However, in addition to these significant external barriers, there are also patient-level barriers that challenge these underprivileged communities with depression.

### Patient-Level Barriers

Patient attitudes regarding mental illness and the stigma surrounding mental illness can prevent racial and ethnic minorities from seeking treatment. Brown et al. [45] found that Blacks had more negative attitudes toward depression treatment as compared to whites. These personal attitudes toward mental health in turn influence whether people seek treatment. Gary [51] explored the role that racial prejudice and discrimination play for racial and ethnic minorities seeking treatment for mental health. She argued that individuals from historically disadvantaged groups experience both public stigma and self-stigma which, when experiencing any form of mental illness, has a compounding effect that creates a *double* stigma: of being part of a minority group as well as having a mental illness. When experiencing any form of a mood disorder, including depression, Gary also argued that a level of denial is an additional part of the resistance to seek treatment when experiencing any mood disorder, including depression. The combination of negative perceptions and mistrust toward mental healthcare systems, as well as negative feelings toward mental health providers, may lead racial and ethnic minorities to avoid the stigma of mental health systems altogether. Ward and colleagues [52] directly assessed coping behaviors and beliefs toward seeking mental health treatment in Black women. They found that participants believed that having mental illness leads to severe consequences, such as hospitalization or jail [52]. If participants were to seek treatment, they preferred counseling over medication due to reservations about potential side effects. Researchers found that most of the barriers preventing participants from seeking treatment included lack of knowledge about seeking mental healthcare, embarrassment related to mental illness, and fear of the stigma associated with mental illness [52].

Finally, practical barriers exist—which can be a result of patient-level barriers and beliefs based on prior experience with structural barriers. For example, personal worries regarding transportation or scheduling of mental health visits, concerns regarding costs, and the fear that one may be treated unfairly due to race or ethnic background, have all been found to be significantly more present for Latino patients in the United States compared to European Latino patients [53]. Given the complexity of these barriers to care for racial and ethnic minorities, more work needs to focus on a multilevel approach to improve screening and diagnosis of illness, treatment access, and quality care for these underserved populations with depression.

### Challenges with Treatment Retention

Once racial and ethnic minorities access care, they may have difficulty continuing mental health treatment. In a study of a nationally representative sample of racial and ethnic minorities (Blacks, Latino Americans, and Asian Americans), Blacks and Asian Americans with history of depression within the past 12 months were less likely than whites to remain in treatment despite their continued clinical need [54]. In addition, Blacks were less likely to continue psychiatric treatment compared to other minority groups. Some of the variation in these differences may also be based on negative patient perceptions regarding antidepressant use. For example, one study within the review demonstrated that Latinos and Black patients were less likely to be taking antidepressant medications than whites, even though no differences were found in patient reports of their primary care providers' recommendations for treatment [55].

Researchers have found that Blacks, Latino Americans, and Asian Americans were all less likely to receive standard depression care in comparison to whites. For example, Alegria et al. [44] found that compared to whites, racial and ethnic minorities received less standard depression care; in Alegria's study, standard depression care was defined as receiving either (1) antidepressant use for the past month combined with four or more treatment visits in the past year or, (2) eight or more treatment visits that were at least 30 min, but without antidepressant use, in the past year. Indeed, Fortuna et al. [54] found that when Black, Latino American, and Asian American patients were seen by a mental health specialist (versus a primary provider) and were prescribed medication (versus therapy alone), they were significantly more likely to remain in treatment. In fact, Fortuna and colleagues found that the type of provider had the greatest impact on treatment retention; patients in treatment with a mental health specialist (versus a primary care provider) were more likely to remain in treatment. Underlying reasons for disparities in retention include the lack of diversity of mental health clinicians, lack of training in cultural sensitivity, low treatment effectiveness, and clinician bias and stereotyping, all of which have an impact

on clinician treatment alliance with patients [32]. Alegria and her colleagues concluded that having increased access to mental health professionals trained in cultural sensitivity could potentially improve treatment retention for racial and ethnic minorities [44].

## Clinical Applications and Recommendations

To elucidate the appropriate diagnosis and treatment for racial and ethnic minorities with depression, providers need to spend sufficient time and attention to cultural factors that affect an individual patient's distress. In this section, we highlight trends in clinician diversity, education, and training, including the advances in the DSM-5 regarding culture. We conclude by giving specific recommendations regarding therapy and pharmacotherapy.

## Cultural Competency Debates

While the demographic profile of patients is changing rapidly, the demographic profile of mental health professionals is changing more slowly [56]. A 2013 survey found that a majority of psychologists were white and female (83% and 68.3%). Between 2005 and 2013, the percentage of racial and ethnic minority groups within the psychology workforce grew from 8.9% to 16.4%, compared to 39.6% for the overall workforce and 25.8% for the general doctoral/professional workforce [57]. Despite these advances, rates of Asian American, Black, and Latino American psychologists have continued to remain low (4.3%, 5.3% and 5%, respectively in 2016) [58]. Similarly, in 2013, the racial and ethnic breakdown of American physicians in practice was: non-Hispanic white (43.0%), Latino (4.0%), Black or African American (3.7%), Asian (10.9%), Native American/Alaskan Native (0.3%), other (0.4%), and unknown (37.7%) [59]. For US-trained psychiatrists, the numbers of minorities are even lower than those in the overall US physician workforce [60, 61]. For social workers, the situation is slightly less dire; in 2015, 67.3% of social workers were white, followed by 23.3% Black social workers and 5.3% Asian Americans [62].

In a survey of 689 psychologists, the majority of whom were white, more than 80% reported discussing racial or ethnic differences in at least one cross-racial therapeutic encounter in the previous 2 years [63]. Yet, the psychologists surveyed also reported that racial or ethnic differences were discussed in less than half of all cross-racial clinical sessions, a finding that is particularly surprising, as racial and ethnic identity is central to an individual's experience in the world, similar to sexual or gender identity. Understanding a racial or ethnic minority individual's cultural identity may be crucial to developing a therapeutic alliance and treatment

plan. Indeed, with the demographic composition of the United States rapidly evolving, ongoing efforts should be made to increase both the diversity of the mental health provider workforce and the capacity and skill of providers to deliver quality healthcare for diverse patient populations. Training focused on fostering an attitude of cultural respect will help equip providers for this challenge. Efforts to create and recruit a diverse mental health provider workforce should proceed in tandem with efforts to cultivate a culturally respectful mental health provider workforce [61].

Because of this, the term "cultural competence" has become *au courant*, as a clinical solution to bridge the disparities in depression care access and treatment for racial and ethnic minorities specifically, given how centrally racial and ethnic minority status may inform one's cultural identity. Culture itself is a broad term, encompassing "the customary beliefs, social forms, and material traits of a racial, religious, or social group," and individuals can belong to several cultural groups based on their racial, ethnic, religious, or family backgrounds [20]. Thus cultural competency can be defined as, "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations" [64].

Cultural competency encompasses systems as well as individual therapeutic encounters. Betancourt and colleagues [11] define three levels for cultural competence interventions: organizational (leadership/workforce), structural (processes of care), and clinical (provider-patient encounter). They note that at the clinical level, training has often focused on a categorical approach which involves ascribing attitudes, values, beliefs, and behaviors to broad cultural groups – which may lead to stereotyping. Combining knowledge-based training with training in the process of cross-cultural communication allows for a more nuanced understanding of how cultural content may or may not be relevant to individuals. There is some evidence that cultural competence training can lead to increased knowledge and awareness among providers, but it is unclear at this point whether training also improves patient outcomes, and more research is needed in this area.

Cultural competence is not uniformly accepted as a core competency in therapy. Sue and colleagues [65] summarize debates on the utility of cultural competence through a series of questions. These include whether cultural competence stereotypes minorities, 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 on therapists to ascribe to cultural competency in order to be viewed as non-racist. The authors respond by noting that the debates 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 our patients. Ultimately, the authors argue that cultural competence is necessary as a response to a historical context resulting in systematic bias against including culturally-specific experiences in therapy.

At the same time, however, research has been limited on how such interventions improve patient outcomes in racial and ethnic minority groups. In one review article evaluating the effect of cultural competence trainings on both patient, professional, and organizational outcomes, researchers found no evidence of improved treatment outcomes or evaluations of care based on cultural competence interventions [66]. In addition, they found that none of the studies evaluated potential adverse events of such interventions. Therefore, while there have been initiatives to address these issues of clinician bias and discriminatory behavior within the healthcare system through education, whether these interventions are effective based on the data provided is still unknown. Future research must focus on how to both better design and evaluate cultural competence interventions.

Qureshi and colleagues [67] note that the term "cultural competence" itself may obscure important distinctions in the types of barriers faced by racial and 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, the authors also argue that racial and ethnic bias, discrimination, financial or structural barriers presented by poverty, immigrant status, and other experiences linked to minority status are not "cultural"; rather, these are structural challenges disproportionately experienced by members of non-white racial and ethnic groups. Clinicians must therefore be prepared to address a wide range of possible experiences impacting their patients; however, many current training models focus primarily on acquisition of knowledge rather than on development of skills or examining attitudes that ultimately may prove to be more useful. Thus "cultural humility" is the "ability to maintain an interpersonal stance that is open in relation to aspects of cultural identity that are most important to the patient" [68]. The culturally-humble clinician is able to express respect and a lack of superiority with regard to the patient's culture; they do not assume competence in terms of working with a particular patient simply based on prior experience with other patients from similar backgrounds.

Finally, there are emerging efforts in medical education to focus on "structural competency" of clinicians, as a means to address disparities in clinical care. Structural competency is defined as "the ability for health professionals to recognize and respond with self-reflexive humility and community engagement to the ways negative health outcomes and lifestyle practices are shaped by larger socioeconomic, cultural, political, and economic forces" [47].

This represents a recent shift in medical education "toward attention to forces that influence health outcomes at levels above individual interactions" [69]. More work will be needed to fully develop curricula to address structural competency for trainees, as well as continuing education for clinicians in practice.

## Culture and the DSM-5

Taking the debates regarding cultural competency into account, the Outline for Cultural Formulation (OCF) was first developed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Revision (DSM-IV), to help clinicians gather and organize data as they care for their patients of diverse backgrounds. This includes information-gathering regarding patient explanatory models of illness, for diagnostic clarification and for treatment planning, taking the larger familial, community, and structural factors into account. The OCF includes five sections: (1) cultural identity of the individual, (2) cultural conceptualizations of distress (cultural explanations of the individual's illness), (3) psychosocial stressors and cultural features of vulnerability and resilience (cultural factors related to psychosocial environment and functioning), (4) cultural features (elements) of the relationship between the individual and the clinician, and (5) overall cultural assessment (for diagnosis and care); the OCF is reviewed in detail below [70, 71].

Despite wide interest in and use of the OCF, substantial barriers to its adoption and implementation have also been reported; these include the format being too vague and unstructured and a lack of clarity about how the OCF fits into standard clinical practice [72]. More recently, the culture workgroup of the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) [73] proposed a number of significant changes to the way culture is conceived and utilized by mental health clinicians and others interested in psychiatric diagnosis. DSM-5 explicitly states that "all forms of distress are locally shaped, including the DSM disorders." As such, the discussion of each disorder contains multicultural explanations for similar symptoms for direct use by clinicians as a cross-reference. For example, panic disorder contains a discussion of *ataque de nervios*, a well-known condition similar to panic attacks primarily seen in Latino individuals, though with some notable differences. Section III of DSM-5 contains two important updated tools for clinicians: an updated Outline for Cultural Formulation and the Cultural Formulation Interview (CFI), which operationalizes the OCF. The current CFI is a standardized, manualized interview based on 16 stem questions and probes, which has been tested for feasibility, acceptability, and clinical utility in a DSM-5 field trial [74].

## The DSM-5 Outline for Cultural Formulation

The DSM-5 emphasizes that a clinician must take into account an individual's ethnic and cultural context in the evaluation of each DSM-5 disorder. This process, called "cultural formulation," includes five distinct components.

### Cultural Identity of the Individual

It is important to consider racial, ethnic, and cultural references, as well as the degree to which an individual is involved with his or her culture of origin (versus the culture in which he or she lives). It is crucial to listen for clues and to ask specific questions concerning a patient's cultural identity. For instance, an Asian American individual who grew up in the Southern United States may exhibit patterns, behaviors, and views of the world more consistent with a Caucasian American southerner. Language abilities, preference, and pattern of use must also be considered to address difficulties accessing care and to identify the need for an interpreter. In addition, attention to religious affiliation, socioeconomic background, country of origin, migrant status, and sexual orientation may be considered important aspects of cultural identity.

### Cultural Conceptualizations of Distress

How an individual understands and experiences his or her symptoms is often communicated through cultural syndromes and idioms of distress (e.g., "nerves," possession by spirits, somatic complaints, or misfortune). Thus, the meaning and severity of the illness in relation to one's culture, family, and community should be determined. This "explanatory model" may be helpful when developing an interpretation, diagnosis, and treatment plan.

### Psychosocial Stressors and Cultural Features of Vulnerability and Resilience

It is important to identify psychosocial stressors and supports within a patient's environment (e.g., religion, family, or social circle). Cultural interpretations of social stress and support, and the individual's level of disability and function, must also be addressed. It is the physician's responsibility to determine a patient's level of functioning, resilience, and disability in the context of his or her cultural reference groups.

### Cultural Features of the Relationship Between the Individual and the Clinician

Cultural aspects of the relationship between the individual and the clinician, as well as of treatment, should be considered. Common barriers for clinicians include difficulties with language, establishing rapport, and eliciting symptoms or understanding their cultural significance.

### Overall Cultural Assessment for Diagnosis and Care

The formulation concludes with a summary of the implications of each component outlined above for psychiatric diagnosis, treatment, and other clinically relevant issues. This step directly acknowledges the fact that each society establishes its own criteria regarding which forms of behavior are acceptable or abnormal, and which behaviors represent a medical problem—all of which bears on the way mental healthcare is conceived of and delivered.

## The DSM-5 Cultural Formulation Interview

DSM-5 also includes the Cultural Formulation Interview, a semi-structured interview composed of 16 questions that physicians can use to assess the influence of culture on a patient's clinical presentation and care. The CFI focuses on four domains of assessment: (1) cultural definition of the problem; (2) cultural perceptions of the cause, context, and support of the problem; (3) cultural factors affecting self-coping and past help-seeking; and (4) cultural factors affecting current help-seeking. The interview aims to avoid stereotyping as it centers on the individual and incorporates the cultural knowledge of the patient, as well as the social context of his or her illness experience. The CFI may be utilized when physicians experience difficulties in diagnostic assessment due to cultural differences, difficulties in determining illness severity or impairment, disagreements with patients regarding course of treatment, or difficulties engaging patients in treatment.

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 perceiving data at multiple levels of awareness [74]. Others have noted that, despite the presence of the CFI in the DSM-V, the overall manual still relies primarily on a conceptualization of mental health that is individually-focused and not embedded in a social context including exacerbating factors such as racism and discrimination [75]. Critiques aside, 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.

## Treatment Recommendations

Understanding the impact of race and ethnicity on treatment—including therapeutic considerations, psychopharmacology, and psychobiology—is necessary to ensure that high-quality care is provided for racial and ethnic minorities. Both therapeutic and biological issues can affect clinical practice.

## Therapeutic Issues Affecting Clinical Practice

As discussed above, culturally-shaped beliefs play a major role in determining whether an explanation and treatment plan will make sense to, and be accepted by, an individual patient. While evidence-based psychosocial therapies for depression (e.g., cognitive behavioral therapy and interpersonal therapy) were initially developed and tested on white middle-income populations [76], the scientific literature available clearly demonstrates that evidence-based care for depression improves outcomes for African Americans and Latinos, and that results are at least equal to or greater than for white Americans. Much fewer data are available for Asian populations, but the literature that is available suggests that established psychosocial care may well be effective for this population [77]. A recent meta-regression in 2017 of 56 randomized controlled trials of psychotherapy found a moderate effect size ($g = 0.50$) in favor of psychotherapy, with no significant moderating effect of race or ethnicity in bivariate and multivariate analyses [31]. Psychotherapy was defined in this study as (1) an intervention in which verbal communication between a therapist and a client was the core therapeutic element or (2) in which a systematic psychological method was conveyed in print or on a Web site (bibliotherapy) for the client to work through more or less independently but with some kind of personal support from a therapist (by telephone, e-mail, or otherwise). Findings from this meta-regression suggest that multiple psychotherapy modalities are equally effective, regardless of the care seekers' race or ethnicity; thus the authors of this study suggested that future research should focus on "filling the gap between effective mental health care and the delivery of these services" [31].

Regarding the extent to which interventions need to be culturally adapted to be effective for minority populations, Miranda and colleagues argue "that all psychosocial interventions are tailored to the individual being served. If we were treating medically ill patients for depression, we would address the impact of illness on mood. If we were treating impoverished patients for depression, we would develop lists of pleasant activities that include many opportunities that are either free of charge or have minimal costs attached. Similarly, when treating Latina women, we would be aware that we may need to encourage them to take care of themselves in order to care for their families, as we know that they may not feel focusing on themselves is appropriate" [77]. Thus, a perspective of cultural humility and structural competency gained from training in these areas may be most helpful as clinicians adapt treatments for culturally-sensitive care.

## Therapeutic Issues Affecting Pharmacotherapy

Patient adherence may be affected by incorrect dosing, by medication side effects, and by polypharmacy. Some racial and ethnic minorities might expect rapid relief with treatment and are wary of potential side effects (including addiction) induced by Western medicine. Traditional and/or alternative methods are often utilized by minority populations. For example, some Asian Americans, Latinos, and Blacks frequently use herbal medicines, which may interact with psychotropic medications. The Japanese herbs *Swertia japonica* and kamikihi-to and the Cuban *Datura candida* have anticholinergic properties that may interact with tricyclic antidepressants (TCAs) or with low-potency antipsychotics. South American holly, *Ilex guayusa*, has a high caffeine content. The Nigerian root extract of *Schumanniophyton problematicum* (which is used to treat psychosis) is sedating and may interact with antipsychotics and benzodiazepines. The Chinese herbs *Fructus schisandrae*, *Corydalis bungeana*, *Kopsia officinalis*, *Clausena lansium*, muscone, ginseng, and *Glycyrrhiza* increase the clearance of many psychotropic medications by inducing cytochrome P450 (CYP) enzymes which metabolize certain psychotropic medications. Oleanolic acid in *Swertia mileensis* and *Ligustrum lucidum* also inhibit CYP enzymes. An herbal weight loss supplement containing *Ephedra sinica* (Ma-Huang), which is the main plant source of ephedrine, can induce mania and psychosis [78].

Other patient-level and structural factors affecting pharmacotherapy can include a poor therapeutic alliance, a lack of community support, money, or transportation, as well as substance abuse or concerns about a medication's addictive potential. Communication difficulties and gap between a patient's "explanatory model" and that of his or her treater (including the cause of distress, the reason for use of medications, and their anticipated side effects) can play an important role in why a person from a racial or ethnic minority background is significantly more likely to be nonadherent to prescribed medications or to drop out of treatment entirely.

## Biological Aspects of Psychopharmacology

Understanding how pharmacokinetics and environmental factors relate to different racial and ethnic populations can help clinicians predict side effects, blood levels, and potential drug-drug interactions, with the strong caveat that though enzymatic patterns may exist in certain racial and ethnic groups, biology of course is only one part of the clinical equation. Pharmacokinetics depends on absorption, distribution, metabolism, and excretion, and the activity of liver enzymes is controlled genetically, although environmental factors can also alter activity. Pharmacokinetics may be influenced by genetics, age, gender, total body weight, environment, diet, toxins, drugs, alcohol, and disease states. Environmental factors include medications, drugs, herbal medicines, steroids, sex hormones, caffeine, alcohol, constituents of tobacco, and dietary factors.

The CYP 2D6 isoenzyme metabolizes many antidepressants, including the tricyclic and heterocyclic antidepressants, and the selective serotonin reuptake inhibitors (SSRls). CYP 2D6 also plays a role in metabolizing antipsychotics, including clozapine, haloperidol, perphenazine, risperidone, and thioridazine. The incidence of poor metabolizers at the CYP 2D6 ranges from 3 to 10% in Caucasians, 1.9 to 7.3% in African Americans, 2.2 to 6.6% in Latinos, and approximately 0 to 4.8% in Asians [79]. Another genetic variation of the metabolizer gene leads to "intermediate metabolizers" or individuals who exhibit CYP 2D6 activity that is between that of poor (little or no CYP 2D6 function) and extensive metabolizers (normal CYP 2D6 function). Approximately 18% of Mexican Americans and 33% of Asian Americans and African Americans have this gene variation [79]. This may explain some of the ethnic differences in the pharmacokinetics of antipsychotics and antidepressants.

The CYP 2C19 isoenzyme is involved in the metabolism of diazepam, clomipramine, imipramine, and propranolol; it is inhibited by fluoxetine and sertraline. The rates of poor metabolizers of this enzyme are approximately 3–6% in Caucasians, 4–18% in African Americans, and 18–23% in Asian Americans [79].

With the above in mind, some of the following clinical observations can be made concerning the use of psychotropic medications in different racial and ethnic minority groups, though clearly intragroup variability can exist. Asian Americans tend to require lower doses of tricyclic antidepressants (TCAs), whereas African Americans may respond faster to TCAs and at lower doses, but with a greater risk of neurotoxicity. Latino Americans may respond to lower doses of TCAs and experience greater side effects. Asian Americans may experience extrapyramidal symptoms (EPS) at a greater rate than African Americans, Latinos, and whites. Asian Americans appear to respond better to clozapine as well as to have greater side effects at lower doses and also appear to be more sensitive to benzodiazepines, compared with whites. Asian Americans appear to respond to lower levels of lithium (with literature suggesting they can be successfully maintained at serum levels of 0.4–0.8 mEq/L), while some African Americans appear to have a greater risk of neurotoxicity, likely related to a slower lithium-sodium pathway and a higher propensity for hypertension [80].

Yet, even with these "rules of thumb" in mind, a culturally-humble clinician must realize that biological variations are only a part of the clinical equation. Not only are significant interindividual variations common, apart from a patient's biology and metabolism of medications, as we have explored, significant macrolevel, social factors (financial, structural) and individual patient-level factors can all intersect in the clinical encounter.

**Case Vignette: Conclusion**

*After the patient's discharge from the hospital, there is a several-week wait for the patient to see the psychiatrist in his clinic; however, the patient's daughter leaves messages that her mother is doing well, going to the senior center daily, and taking the medication as prescribed. Prior to meeting the patient for the first outpatient appointment with the patient and her daughter, the psychiatrist reviews in advance the case's "cultural formulation" to identify parts of the patient's presentation to explore more with the patient and her daughter.*

1. *Cultural identity of the individual: 55-year-old widowed self-identified Black woman originally from Georgia. She moved to be closer to her daughter's family 6 months ago and was able to join her daughter's church.*
2. *Cultural conceptualizations of distress: She describes her challenges as stemming from being "lonely," causing her to not feel like eating, sleeping, or doing much of anything. She was concerned about seeking mental healthcare initially, worried about the stigma as being seen as "crazy" if she were to talk with a mental health clinician.*
3. *Psychosocial stressors and cultural features of vulnerability and resilience: She describes her daughter's family and her daughter's church and church community as a source of support; her daughter believes the senior center is becoming a source of support as well, which has served to combat her sense of isolation.*
4. *Cultural features of the relationship between the individual and the clinician: The patient and her family are encouraged that the psychiatrist knows their church's pastor and is part of the same broader church community. Also, the psychiatrist's having cared for the patient and her family in the hospital deepens the connection between the psychiatrist and the patient.*
5. *Overall cultural assessment for diagnosis and care: This is a widowed woman who presents with depressive symptoms in the context of social isolation, though she does have family and church support. She has been able to develop an alliance with the psychiatrist based on a feeling of shared racial and faith-based background, which will help foster trust as they navigate together pharmacotherapy treatment focused on her symptoms, as well as psychosocial support to address the patient's psychosocial trigger (social isolation) for her depression.*

*Reviewing this case, the psychiatrist realizes it would be helpful to explore more in depth with the patient 1) her racial and cultural identity, and how it informs her explanatory model of illness, 2) flesh out the meanings behind her stressors and supports, and 3) understand more explicitly her expectations for the treatment relationship. With these goals in mind, the psychiatrist refers to the relevant sections of the CFI to prepare his questions for the first visit.*

## Conclusion

Disparities in diagnosis, access, and treatment of depression in racial and ethnic minorities in the United States are a persistent and pressing clinical, public health, and public policy challenge. Ultimately, multipronged interventions at the financial, structural, and patient level will be needed to reduce disparities and ensure equitable access to treatment for all racial and ethnic minority groups. Clinicians can be part of this effort by educating themselves on how to best approach the interview, diagnosis, and treatment of racial and ethnic minorities with depression. Future efforts should not only address how to better train mental health clinicians to care for racial and ethnic minorities, but should also seek innovative ways to improve the structure barriers of our healthcare system and inform local communities about the benefits of such mental healthcare options.

## FAQs: Common Questions and Answers

**Q1**. What's the best way to approach a patient from a racial or ethnic minority background different from my own?

**A1**. Realize that patients from different cultural backgrounds may have unique needs and issues that require additional time and resources. The clinical relationship will be more complex, and it will likely take longer to develop trust and alliance. Be respectful to all patients and address them formally (e.g., Mr., Ms., Mrs.), particularly early in the treatment relationship, before an alliance is well established.

**Q2**. What is the best initial approach for engaging racial and ethnic minorities in psychiatric treatment?

**A2**. Understand how personal biases and stereotyping may affect treatment. Beginning the initial therapeutic encounter with a minority patient, as with any patient, requires that the clinician put the patient at ease in order to develop rapport and a willingness to work together over time. Many depressed minority patients may have somatic complaints; therefore, beginning the discussion with the medical aspects of their health often is a good way to "break the ice". That being said, racial and ethnic groups are highly heterogeneous and may include a diverse mix of individuals with different cultures, overlapping identities, languages, practices, and experiences. Be careful not to make assumptions about a patient's values or behavior based on race, ethnicity, or culture, as such generalizations can be misleading and have harmful effects on a patient.

**Q3**. How can I overcome obstacles to clinician-patient communication when treating populations of ethnic backgrounds different from my own?

**A3**. Confronting challenges with communication: Assure patients about confidentiality, as it may be important due to shame, fear, or paranoia related to prior traumatic experiences. Pay attention to communication (e.g., non-verbal communication, expressive styles, and the connotations of words). Anticipate that the patient may have mistrust or fear of treatment due to prior poor experiences with healthcare systems.

**Q4**. How can I address diagnostic considerations in these populations?

**A4**. Considering diagnostic dilemmas: If a diagnosis is unclear or might be impacted by ethnicity or culture, consider employing a structured diagnostic interview tool (such as the Cultural Formulation Interview) to reduce the possibility of misdiagnosis. Consider interviewing patients with a bilingual, bicultural interpreter, who can facilitate the education of patients and families to reduce stigma surrounding mental illness. Consider obtaining a curbside consultation from a clinician of the relevant ethnic background (if available).

**Q5**. What particular medication considerations should I keep in mind for these populations?

**A5**. Considering medication choices: When encountering a patient of a particular ethnic background, one should avoid assuming every such patient will tolerate the same doses of medications. Be prepared to start with lower medication dosages and increase the dose slowly (as tolerated and as clinically indicated). In addition, be sure to ask about the use of herbal medicines, since use of these agents has increased dramatically in the United States in the past few decades. Remember that drug-herbal medicine interactions exist and should be carefully considered.

**Q6**. What about including family members in treatment?

**A6**. Involving family: As for all patients, providers should request consent prior to talking to and engaging family members in treatment. Both the way family members interact with one another and the family functions as a whole have a significant impact on psychiatric treatment. Many racial and ethnic minorities have a "closed network" that consists of multiple family members, kin, and intimate friends. Some may rely on interactions with

relatives for social support, and some become more demoralized when such interactions do not increase with treatment. Racial and ethnic minorities may request to have members of their extended family involved in their treatment, including discussions with their providers. Family members may be able to provide collateral information and be a source of emotional and practical support for patients. In some cases, family consensus may be desired by the patient prior to engaging in a particular course of treatment, and the clinician should be attuned to such familial dynamics.

**Q7**. What can I do to increase retention of racial and ethnic minorities in my practice?

**A7**. Improving adherence: In addition to the tips above, focusing on practical barriers faced by patients and their families (challenges with making and keeping appointments, insurance issues, etc.) may be helpful for racial and ethnic minorities. Providers can set the tone by engaging patients and their families in conversations regarding using their preferred vocabulary (rather than medical jargon) and by focusing on the patient's goals—which may not always overlap with our clinical focus. The use of well-trained interpreters who possess knowledge of the patient's understanding of treatment recommendations can also significantly impact adherence. Other factors to consider regarding adherence include misdiagnosis of a psychiatric condition, a placebo response, mistrust of the healthcare system, attention seeking at a later stage of illness, and cultural beliefs and expectations regarding treatment.

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