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ORIGINAL PAPER

The Role of Culture/Ethnicity in Communicating with Cancer Patients About Mental Health Distress and Suicidality

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Abstract To explore the role of culture in communicating with cancer patients about mental health distress and suicidality. The Grounded Theory method of data collection and analysis was used. Healthcare professionals (HCPs) reported that language competency was a facilitator while being unable to speak the language or understand the nuances of their patient's communication could be a barrier. HCPs noted that being culturally matched with their patients helped them communicate effectively. HCPs also spoke about religious taboos on suicide as being a barrier to having conversations, either because patients did not feel comfortable discussing these issues, or because they perceived that this was not a topic they could bring up. Some HCPs reported that the culture/ethnicity of their patients had no effect on their ability to communicate effectively with them about mental health distress or suicidality. Advancing effective cross-cultural communication is a challenge faced by HCPs. Raising awareness about communication styles is an important step in addressing communication gaps about mental health and suicide with cancer patients. Training should facilitate skill development to engage in a culturally

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humble approach to cross-cultural communication including diversity training which encourages asking and actively listening to patients' needs and preferences.

Keywords Doctor–patient communication · Oncology · Ethnicity · Culture · Suicide

Introduction

Mental Health Distress and Suicidality in Cancer Patients

A cancer diagnosis is a life-changing event that can be accompanied by a host of negative sequela including depression and anxiety (Blow et al. 2011; McLoone et al. 2012; Nakash et al. 2014). People with cancer are at an increased risk for suicidal ideation (Walker et al. 2011), suicidal attempts (Allebeck and Bolund 1991), and suicidal acts (Hem et al. 2004; Nakash et al. 2013) and can suffer from substantial distress during treatment (Mitchell et al. 2011; Nakash et al. 2014). Despite the awareness of the need to provide holistic care that includes psychological support, evidence shows that healthcare professionals (HCPs) often fail to identify distress in patients and that there is a large gap between patients' need for support and the treatment they receive (Gouveia et al. 2015; Jacobsen and Wagner 2012; Nakash et al. 2014). Barriers to identifying distress include lack of screening tools, time constraints, difficulty in differentiating between the physical signs of cancer and mental health distress, and insufficient referral guidelines (Absolom et al. 2011; Biddle et al. 2016; Granek et al. 2018). Barriers to identifying suicide risk include patients showing no warning and concealing suicidal thoughts, difficulty in differentiating normative mental health distress from suicidality, lack of time, fear, discomfort asking about suicidality, and lack of resources to cope with patients endorsing suicidality (Granek et al. 2017).

The Role of Culture in Communicating with Cancer Patients About Mental Health Distress and Suicidality

While there is growing awareness, particularly in the mental health professions, for the need to take culture and race/ethnicity into account when providing care, this issue has received less attention in oncology (Schrank et al. 2017). In different medical fields, research has documented that cultural factors can affect communication about mental health distress in primary care (Ghods et al. 2008; Kales et al. 2005; Sleath and Williams 2004) and in elder populations (August et al. 2011; Sorkin et al. 2016; Sorkin et al. 2011). In the cancer context, the research has addressed culture more broadly, looking at a variety of ways in which the race/ethnicity/culture of the patient intersects with their experience in the healthcare domain.

Communication with minority patients and immigrants, particularly about their cancer diagnosis and prognosis, has received the most research attention (Flores 2005; Palmer et al. 2014; Schrank et al. 2017). For example, one study that looked

at culturally sensitive care in oncology and in palliative care found that staff reported language barriers hindered them from providing good care for migrant patients (Schrank et al. 2017). Another Australian study found significant differences in the quality and types of communication oncologists provided to immigrant versus native born patients. These gaps were particularly pertinent around discussing emotional issues. For example, fears or concerns about the prognosis were discussed 16% of the time with native patients, and only 9% of the time with immigrants who used interpreters. The native-born patient was encouraged to express their feelings 77% of the time, while the immigrant patient was encouraged to do so only 56% of the time (Butow et al. 2013). Finally, another recent study found that in a sample of 38 oncologists, 82% reported uncertainty and discomfort working with minority patients, primarily due to communication and language barriers. In addition, this study found that HCPs felt that minority patients received less psychosocial and emotional support than native born patients (Watts et al. 2017).

Other research in the cancer field has focused on how culture and race/ethnicity of patients might affect the way that patients discussed their concerns with physicians. For example, one study that looked at American and immigrant born Chinese women who survived breast cancer found that their expressions of symptoms were distinct to Chinese culture, using descriptive dichotomies like 'hot and cold imbalances' rather than North American descriptions of these symptoms. The authors reflected that cultural norms affected how the women communicated with their physicians about their needs and/or challenged them when their needs were not being addressed (Wang et al. 2012).

Approaches to Promoting Effective Cross-Cultural Communication With Patients

The increasing cultural, racial, and ethnic diversity of the patient population in many Western countries has compelled healthcare systems to identify ways to promote effective cross-cultural communication. When communicating with someone whose cultural background differs from one's own, processes pertaining to different social categorization may impact the ability to form a good patient-physician rapport. First, the different group identities might cause difficulties in understanding and correctly interpreting the patient's information, also known as a cultural dysfluency effect (Oyserman 2011). Second, given the high level of uncertainty and time constraints that characterizes medical encounters, HCPs may be prone to use social categorization and bias in their decision-making processes (Cooper et al. 2012; Green et al. 2007).

Given the accumulating research over the last two decades suggesting that the identities of providers and patients impact patient-provider communication, an extensive body of research has examined whether concordance (match) in socio-cultural identities of patients and providers can improve communication and overall quality of care (Chu et al. 2016; Nakash and Saguy 2015; Thornton et al. 2011). The match theory in the medical context suggests that the best service is provided when healthcare workers come from the same cultural or ethnic/racial background, and

thus, have both the language and cultural competency to communicate effectively with clients (Thornton et al. 2011). Empirical studies on this "matching" hypothesis were mostly conducted in the context of behavioral healthcare and primary care focusing on ethnic/racial matching and produced mixed results (Cabral and Smith 2011; Thornton et al. 2011). Studies focusing on communication during mental health visits found that ethnic/racial concordance promoted patients centred communication among some minority groups (e.g., Latino) (Alegría et al. 2013).

An additional approach to promote effective cross-cultural communication advocates for developing cultural competence in HCPs. Components of multicultural competencies include attitudes/beliefs, knowledge and skills that promote a patient centered approach to care that carefully considers the patient and the provider's socio-cultural background in the care provided (Teal and Street 2009). Culturally competent communication incorporates assessment of cross-cultural relations, social structures and power differentials, expansion of cultural knowledge, and adaptation of communication to meet culturally unique needs (Betancourt et al. 2016).

Finally, a third approach to advance cross-cultural communication has employed cultural brokers and cross-cultural consultations (Kirmayer et al. 2003; Singh et al. 1999). This approach employs a third party, who has the relevant cultural expertise to directly assess and/or be involved in the delivery of care for the patient, preferably with the participation of the referring clinician. The consultant mediates between the patient and provider about needs and preferences.

The Present Study

This study took place in Israel, which is a mosaic of ethno-national-religious-cultural identities that embraces diverse groups. The majority of the population (75%) is Jewish, and approximately 21% of the total population is comprised of Arabs (Israel Central Bureau of Statistics 2017). Israel's Jewish population is itself ethnically diverse and includes *Mizrahim* (Jews of Middle Eastern descent) and *Ashkenazim* (Jews of European decent) as well as a large community of immigrants from the Former Soviet Union. The Arab population in Israel is also heterogeneous and includes a large population of Muslims (18%) that reside in urban and rural areas, and smaller communities of Bedouins, Druze and Christians (Israel Central Bureau of Statistics 2017). Given this geographical locale, healthcare providers will be exposed to many patients that come from different cultures and ethnicities other than their own. Nonetheless, to our knowledge, no studies have addressed the intersection of culture and mental health distress and suicidality in cancer patients in Israel or elsewhere. Given the dearth of literature on this topic, this study focused specifically on the role of culture when communicating with cancer patients about mental health distress and suicidality.

Methods

Study Design and Participants

This study was part of a larger project exploring how oncologists, social workers and nurses identify and respond to mental health distress and suicide risk in their cancer patients. The grounded theory method of data collection and analysis was used (Glaser and Strauss 1967). Sixty-one oncology HCPs from two centers in Israel were interviewed about how their own culture or the culture of their patients influences how they communicate about, and identify mental health distress and suicidality in their patients. The sample included 23 oncologists, 18 social workers, and 20 nurses who work in cancer centers. Participant demographics are presented in Table 1.

Procedure

Prior to beginning the study, Research Ethics Board approvals were obtained from each participating center. Potential participants for the research were emailed information and asked to respond if they wished to be contacted. Sixty-one HCPs responded and none declined to be interviewed. Participants signed a consent form, and agreed to the interview being audio-recorded. A semi-structured interview guide was used. Questions pertained specifically to how the cultural or ethnic identity of the healthcare workers (HCPs) and/or the participants affected the HCPs ability to communicate about and identify mental health distress or suicidality. (i.e., Can you tell me about how cultural/ethnic background of your patients affects to your ability to identify mental health distress and suicidal thinking in your patients?)

Data Analysis

Data collection and analysis took place concurrently. Analysis involved line-by-line coding, and was inductive, with codes and categories emerging from participants' narratives. The study PI and a research assistant separately coded the first five transcripts, followed by team discussions on the coding scheme to ensure consistency between coders and validity of the emerging findings. Constant comparison was used to examine relationships within, and across codes and categories. Data collection stopped when we reached data saturation and no new codes were created. NVivo 10 computer software was used to store and organize the data.

Findings

The majority of our participants identified as Jewish (92%). Seventy-two percent identified as Ashkenazi (of European decent), 28% percent identified as Mizrachi (of Middle Eastern decent), and 11% as 'other'. On the whole, HCPs drew on the 'cultural match' approach to service without naming it as such. HCPs named

Table 1 Participant demographics, oncologists (N = 23), social workers (N = 18), and nurses (N = 20)

Characteristic	(N = 61)
Gender % (N)	
Male	14.8 (9)
Female	85.2 (52)
Age[a]	
Mean (SD)	45.7 (10.8)
Family status % (N)	
Married	78.7 (48)
Single	11.5 (7)
Divorced, separated or widow	9.8 (6)
Years in practice % (N)	
Less than 5 years	21.3 (13)
5–15 years	34.4 (21)
More than 15 years	44. 3 (27)
Oncology unit[b] % (N)	
Clinics[3]	45.9 (28)
Day hospital	32.8 (20)
Ward or hospice	32.8 (20)
Radiation	18 (11)
Palliative care	9.8 (6)
Oncology ER	4.9 (3)
Caregivers clinic or psycho-oncology unit	4.9 (3)
Religious background % (N)	
Jewish	92 (56)
Other	8 (5)
Country of birth % (N)	
Israel	62.2 (38)
Former Soviet Union	21.3 (13)
Other	16.3 (10)
Ethnicity % (N)	
Ashkenazi	72.1 (44)
Mizrachi	27.8 (17)
Other	11.4 (7)
No. of patients seen per week % (N)	
5–15	9.8 (6)
16–25	29.5 (18)
26–40	19.7 (12)
More than 40	40.9 (25)

[a]Only 50 participants answered

[b]Some HCPs work in more than one place

[c]Breast, Gastro, Neuro-Oncology, Hemato-Oncology, Ortho, Skin Cancer, Head-Neck, GI, and Oncology Service for the Eye

language competency and cultural match as both facilitators and barriers to effective communication with patients and their families about mental health distress and suicidality. Additional barriers had to do with religious taboos around suicide. Finally, a last group of HCPs reported that the culture or ethnic background of their patients had no effect on their ability to communicate about mental health distress or suicide. Each of these themes is presented in more detail below.

Cultural Facilitators and Barriers in Communicating About Suicidality and Mental Health Distress

Language Competency as a Facilitator

Israel is a multi-cultural society. The formal languages are Hebrew and Arabic, however, because Israel is made up largely of immigrants, HCPs face patients who speak English, Spanish, Russian, Amharic, French, Yiddish, Romanian, German, Turkish, Filipino, Chinese, and Thai, among others. HCPs reported that the ability to speak the language their patients spoke was critical for the patient's well-being, and important for the HCP in order to be able to effectively communicate about, and identify mental health distress and suicidality. On 'language matching', one oncologist remarked:

> If, let's say, a patient speaks English, I'll ask an Anglo-Saxon staff member to speak with them. If the patient is Russian, I ask the technicians who speak Russian. For someone who speaks Arabic, I ask Moroccan or Iraqi Jews to speak with them in their own language.

HCPs also stressed the importance of a language match for their own ability to accurately and competently identify mental health distress and suicide risk. One nurse remarked, "I assume it will be easier for me to identify suicidal ideation in people who speak my language, or I speak their language."

Language Competency as a Barrier

The inability to communicate in the patient's native language was named a barrier in communicating about mental health distress and suicidality. This language barrier referred to both the literal inability to speak to patients and a more nuanced understanding of how different cultural/ethnic groups use language differently to indicate distress. On the inability to understand the language, one oncologist said, "If a Sudanese or Eritrean person who doesn't speak Hebrew comes to see me, I won't know to what degree they have suicidal thoughts or not."

The second language barrier had to do with being able to hear the complex ways in which language and culture interact when discussing issues such as distress and suicide. HCPs explained that even patients who spoke the dominant language, but who came from cultures different than their own had specific ways of communicating about their emotions that they could potentially comprehend linguistically, but not always understand fully. As with language being a facilitator, here too HCPs maintained that the mismatch between cultures was a problem for patients, and for

the HCP, who potentially could be missing the signs of distress. On the inability to understand the nuances in language and communication, this oncologist said:

> I don't hear suicidal expressions from all patients. I hear it from people who feel very good about the society they are in. These are Hebrew speaking people. I can't hear it from Russian speaking people, because there are also matters of culture, of language. These are people who say it in different words that I can't identify. (O)

Cultural Match as a Facilitator

While no HCP explicitly used the term 'cultural match' in their descriptions of facilitators to communication with their patients, they alluded to this concept when discussing the ease of speaking with patients who come from the same cultural background as their own. This understanding of culture referred to the awareness of cultural norms and rules around what could be discussed and the tone in which it could be discussed. On this, one oncologist remarked,

> It's easier for patients who come from South America, as I do, to open up with me. Because they already speak Spanish. But it's not just because of the language. They usually speak Hebrew well. But I understand something that is related to the culture.

Lack of Cultural Match as a Barrier

The cultural mismatch between an HCP and a patient was named as a communication barrier, with the 'problem' often solved by transferring a patient to someone of the same cultural background. On this, one social worker said:

> There's no doubt that I am less capable of reading the types of thinking that can lead to suicidality in a population I don't speak the language or know its nuances. This is why we have a social worker here who is Arabic speaking, so that if we feel a certain patient needs follow up or continuous relationship, we refer them to her. If I see an Arab patient who does not cope well with the disease or is depressed, I'll suggest she'll be transferred to the Arab Social worker. I also tell the patients: I don't think I can talk to you and understand your cultural nuances. I transfer them.

On different cultural presentations of distress as a barrier to identification of mental health distress and suicidality another nurse remarked,

> With some Ethiopian patients I have a hard time guessing if they're suffering, or depressed. It can be a language barrier thing, or a cultural thing. There are people who externalize more, so that the whole world knows what's going on with them. And there are people who do everything quietly and on a small scale. So, I am not sure if it's more of an ethnic thing or also a personality thing with these patients.

Religious Taboos on Suicide as a Barrier

The two dominant religions in Israel, Judaism and Islam prohibit suicide. As such, HCPs reported that these taboos were a barrier to discussing suicidality in patients who identified as religious, but who might otherwise be at risk for these thoughts. On this, one nurse remarked:

> There can be a difference in suicidal ideation between people from religious backgrounds and people from a secular background because there is a prohibition on suicide in religion. So, it could be that a person who grew up in a traditional or religious background will think about it, but will not be able to execute it because of the religious barrier.

While this nurse spoke about the difficulty for patients to discuss these issues because of religious taboos, some HCPs also talked about their own difficulty bringing up these issues because of their assumptions about the cultural acceptability of talking about suicide with certain ethnic groups. For example, another nurse noted, "There are people who come from a certain background in which you talk about suicide less or you're afraid of talking about it. It can be related to religion."

Culture Insignificant to Communication about Mental Health Distress and Suicidality

Another subset of HCPs reported that their own cultural background or the cultural background of their patients had no effect on their ability to communicate about mental health distress and suicidality. As one oncologist said, "I wouldn't say that ethnic origin matters in communication with a patient. It depends on the patient, not the origin. There are some who don't open up and there other who do open up regardless of origin." Another nurse echoed, "I don't think my ethnic background had an effect on my communication with patients. I connect with everybody, irrespective of race or religion. Absolutely."

Discussion

This study explored how oncologists, nurses, and social workers who work with cancer patients perceive the role of culture and ethnicity in communicating with patients about mental health distress and suicidality. While oncologists and nurses, and to a certain degree, social workers cannot be expected to treat mental health distress and suicidality in patients, they are the front-line workers who are responsible for identifying these concerns in patients in order to make a referral to a mental health professional if necessary. HCPs reported that language competency was a facilitator while being unable to speak the language or understand the nuances of their patient's communication could be a barrier. HCPs also noted that being culturally matched with their patients helped them communicate more effectively, while a cultural mismatch was a barrier that was often solved by transferring

patients to another HCP. HCPs also spoke about religious taboos on suicide as being a barrier, either because patients did not feel comfortable discussing these issues, or because the HCP perceived that this was not a topic they could bring up. Finally, some HCPs reported that the culture/ethnicity of their patients had no effect on their ability to communicate effectively with them.

Of the approaches to effective communication with patients from different cultures and race/ethnicities discussed in the introduction (e.g., cultural matching, cultural competence, and using a cultural broker) the participants in this study brought up only cultural match as facilitating their communication with patients, or the opposite, hindering their ability to communicate effectively, The research on this topic in other areas of medicine has documented that a cultural match can indeed facilitate and improve communication between healthcare providers and patients and make it easier to develop rapport (Alegría et al. 2013). One of the recommendations that emerges from our findings is to increase the number of clinicians in oncology from different ethnic/cultural backgrounds in order to meet the needs of an ethnically diverse patient population (Keshet et al. 2015). Even with this initiative, however, the cultural match approach is limited for two reasons.

First, cultural matching is rarely possible for all patients, particularly in places like Israel, which is diverse. Patients are assigned to their healthcare staff based on their disease profile, rather than on their backgrounds. Thus, all HCPs, need to know how to communicate with patients and their families about mental health distress and suicidality. Second, the cultural match approach as it is practiced often assumes that social identities are based only on one dimension and disregards the body of literature on intersectionality within the cancer context (Damaskos et al. 2018; Keshet et al. 2015). For example, an Arab, Christian, homosexual patient may have little in common with an Arab, female, heterosexual, Muslim social worker. The assumptions made by the HCPs in this study, however, and with the cultural approach in general, is that one indicator of social identity, in this case, an Arab background, is enough to form a cultural match and ensure effective communication. Social identities are far more complex and nuanced, however, and it is possible that one dimension of a patient's social identity (i.e., sexual orientation), may be more salient than another (i.e., ethnic background) for promoting effective communication and forming a rapport.

For these reasons, the field has expanded in recent years towards encouraging HCPs to learn cultural competent communication skills (Cooper et al. 2012; Saha et al. 2008). In other areas of medicine, this has proven to be an effective strategy. For example, training physicians in culturally competent communication has shown to improve patient's satisfaction and retention in care (Beach et al. 2005; Cooper et al. 2012; Saha et al. 2008). A recent review of culturally competent communication in the cancer context found that several articles focused on importance of these skills (Brown et al. 2016). While these articles referred to communicating about the disease and its trajectory rather than on mental health distress or suicide, several papers mentioned engaging in culturally sensitive communication (Kagawa-Singer et al. 2010; Surbone 2006), delivering culturally sensitive services (Huang et al. 2009), observing culturally appropriate non-verbal communication etiquette (Kagawa-Singer et al. 2010), and avoiding stereotypes and

generalizations. These articles indicate a positive move towards raising awareness about cultural competence in oncology care.

The importance of raising awareness to multiculturalism and addressing cultural differences in patient-provider communication stands in contrast to the statements expressed by some of the participants in our study that minimized the role culture plays in the medical encounter. Such an approach represents a color blind racial/ethnic attitude to managing cultural differences (Neville et al. 2013). Frankenberg (1993) who discussed the concept of color blindness in the context of American race relations suggested that it encompasses two dimensions: color-evasion, and power evasion. Colour evasion "emphasiz[es] sameness as a way of rejecting the idea of white racial superiority" (p. 147); while power-evasion, promotes the idea that everyone has similar opportunities to succeed. Although the color blindness strategy of "not seeing race/ethnicity" is often expressed as a means to reduce racial bias and promote racial justice, it is unrealistic in heterogeneous societies such as Israel. This approach may cause more harm in multicultural interactions that are characterized by differential social power relations (Neville et al. 2013; Plaut et al. 2018).

Frankenberg's (1993) definition highlights the role of social power in cross cultural encounters and the potential harmful consequences that may arise when power differentials are not acknowledged. Any patient-provider interaction is by definition hierarchical, because the provider is the one with the knowledge and expertise (Goffman 1963). However, in ethnic/race/culture-discordant encounters between a provider from a privileged group and a patient from a minority group another layer of power is added: namely, power by virtue of social group membership. This layer adds to the already existing amount of power-by-social-role, resulting in a provider from a privileged group having overall more social power in the discordant encounter than in a concordant encounter (Nakash et al. 2012).

In order to address these power dynamics that are inherently part of the doctor–patient relationship, in recent years, scholars have offered to move beyond the cultural competence framework, which emphasizes a "way of doing" to embracing a cultural humility approach, which refers to the HCP's "way of being" with the patient (Hook et al. 2016; Ndiwane et al. 2017). Cultural humility is guided by values that promote diversity and equity, while being attentive to structures of power and hierarchy in cross-cultural interactions. In their landmark paper, distinguishing between cultural competence and cultural humility in physician training, Tervalon and Murray-Garcia (1998) summarized that "cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician- patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (p. 123). Maintaining a culturally humble stance requires a degree of openness to others. It is centered around a humble approach that maintains respect and lack of superiority when communicating with the patient (Hook et al. 2013).

Limitations

Our study has limitations. The intent of qualitative research is to gain an in-depth understanding of a phenomenon, and thus, requires smaller sample sizes. The benefit of this approach is that it uncovers rich knowledge and is particularly appropriate to research questions such as the one asked in this study that has been relatively under-studied. The limitation, however, is that it does not allow for the collection of data from larger samples where statistical analyses can shed light on how demographic variables (i.e., years of experience, gender, etc.) may impact the ability of HCPs to communicate about mental health distress and suicidality with patients. Further research using larger samples should explore these questions more broadly as well as address specific attributes and HCPs' lived experiences that may contribute to effective cross cultural communication. Specifically, the vast majority of our sample was Jewish. Although this demographic is representative of the HCPs in Israel, the paucity of ethno-national minorities (e.g., Arabs in Israel) in our sample did not allow us to explore possible ethnic differences in lived experiences and how they may affect cross-cultural communication. Further research might also explore what model of training for HCPs is most effective in implementing a cultural humility approach.

Conclusion

Advancing effective cross-cultural communication is a challenge faced by HCPs in an increasingly diverse world. Training models for HCPs should focus on improving communication skills. Developing active listening and cultivating empathy are critical to open discussion sensitive topics such as mental health distress. Conducting open conversation in a cross-cultural encounter additionally requires raising awareness and promoting knowledge about mental health needs and care preferences including communication styles is an important first step in addressing communication gaps. However, on its own, these steps may overlook power differentials and important structural factors that contribute to the communication gaps.

Practice Implications

Although advances have been made to address communication disparities and understand the role of culture in effective communication, clinical practice has not fully implemented a holistic approach to care that takes into account the socio-cultural dimensions of the patient and the provider. Research from other fields has identified both individual-level factors and contextual influences, which impact effective cross-cultural communication (Dovidio et al. 2008; Nakash and Saguy 2015; van Ryn 2002). This body of work can be used to develop relevant interventions in clinical encounters in oncology care. For example, one intervention can involve diversity training for HCPs, in attempt to educate them about their

potential biases and consequences. Raising awareness to stereotypical thinking, and power relations in interpersonal interactions was found to reduce cognitive biases. Within this context, interventions to promote a culturally humble approach highlight that any communication should be based on curiosity and respect for the other. Asking and actively listening to patients' needs and preferences are essential elements in cross-cultural communication and should be part of training and practice evaluation.

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Compliance with Ethical Standards

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

References

Absolom, Kate, et al.
2011 The Detection and Management of Emotional Distress in Cancer Patients: The Views of Health-Care Professionals. Psycho-Oncology 20:601–608.
Alegría, Margarita, et al.
2013 Patient-Clinician Ethnic Concordance and Communication in Mental Health Intake Visits. Patient Education and Counseling 93:188–196.
Allebeck, Peter, and Christina Bolund
1991 Suicides and Suicide Attempts in Cancer Patients. Psychological Medicine 21:979–984.
August, K.J., et al.
2011 Language Concordance and Patient-Physician Communication regarding Mental Health Needs. Journal of the American Geriatrics Society 59:2356–2362.
Beach, Mary Catherine, et al.
2005 Cultural Competency: A Systematic Review of Health Care Provider Educational Interventions. Medical Care 43:356–373.
Betancourt, Joseph R., et al.
2016 Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. Public Health Reports 118:293–302.
Biddle, Lucy, et al.
2016 Patients' and Clinicians' Experiences of Holistic Needs Assessment Using a Cancer Distress Thermometer and Problem List: A Qualitative Study. European Journal of Oncology Nursing 23:59–65.
Blow, A.J., et al.
2011 The Emotional Journey of Women Experiencing a Breast Abnormality. Qualitative Health Research 21:1316–1334.
Brown, O, et al.
2016 Culturally Competent Patient-Provider Communication in the Management of Cancer: An Integrative Literature Review. Global Health Action 9:1–13.

Butow, P.N., et al.
2013 Should Culture Affect Practice? A Comparison of Prognostic Discussions in Consultations with Immigrant Versus Native-Born Cancer Patients. Patient Education and Counseling 92:246–252.
Cabral, Raquel R., and Timothy B. Smith
2011 Racial/Ethnic Matching of Clients and Therapists in Mental Health Services: A Meta-Analytic Review of Preferences, Perceptions, and Outcomes. Journal of Counseling Psychology 58:537–554.
Chu, Joyce, et al.
2016 A Model for the Theoretical Basis of Cultural Competency to Guide Psychotherapy. Professional Psychology: Research and Practice 47:18–29.
Cooper, Lisa A., et al.
2012 The Associations of Clinicians' Implicit Attitudes About Race with Medical Visit Communication and Patient Ratings of Interpersonal Care. American Journal of Public Health 102:979–987.
Damaskos, P., et al.
2018 Intersectionality and the LGBT Cancer Patient. Seminars in Oncology Nursing 34:30–36.
Dovidio, J.F., et al.
2008 Disparities and Distrust: The Implications of Psychological Processes for Understanding Racial Disparities in Health and Health Care. Social Science and Medicine 67:478–486.
Flores, G.
2005 The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. Medical Care Research and Review 62:255–299.
Frankenberg, R.
1993 White Women, Race Matters: The Social Construction of Whiteness. Minneapolis, MN: University of Minnesota Press.
Ghods, B.K., et al.
2008 Patient-Physician Communication in the Primary Care Visits of African Americans and Whites with Depression. Journal of General Internal Medicine 23:600–606.
Glaser, Barney, and Anselm Strauss
1967 The Discovery of Grounded Theory: Strategies for Qualitative Inquiry. Chicago, US: Aldin.
Goffman, E.
1963 Stigma: Notes on the Management of Spoiled Identity. Englewood Cliff, NJ: Prentice Hall.
Gouveia, Lucie, et al.
2015 Oncologists' Perception of Depressive Symptoms in Patients with Advanced Cancer: Accuracy and Relational Correlates. BMC Psychology 3:1–11.
Granek, L., et al.
2018 Oncologists' Identification of Mental Health Distress in Cancer Patients: Strategies and Barriers. European Journal of Cancer Care 27:e12835.
Granek, Leeat, et al.
2017 Oncologists', Nurses' and Social Workers' Strategies and Barriers to Identifying Suicide Risk in Cancer Patients. Psycho-Oncology 27:145–148.
Green, A.R., et al.
2007 Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients. Journal of General Internal Medicine 22:1231–1238.
Hem, Erlend, et al.
2004 Suicide Risk in Cancer Patients from 1960 to 1999. Journal of Clinical Oncology 22:4209–4216.
Hook, Joshua N., et al.
2013 Cultural Humility: Measuring Openness to Culturally Diverse Clients. Journal of Counseling Psychology 60:353–366.
2016 Cultural Humility and Racial Microaggressions in Counseling. Journal of Counseling Psychology 63:269–277.
Huang, Y.L., P. Yates, and D. Prior
2009 Factors Influencing Oncology Nurses' Approaches to Accommodating Cultural Needs in Palliative Care. Journal of Clinical Nursing 18:3421–3429.
Israel Central Bureau of Statistics
2017 Population Statistics (Vol. 2010). Jerusalem: Israel Central Bureau of Statistics.

Jacobsen, Paul B., and Lynne I. Wagner
2012 A New Quality Standard: The Integration of Psychosocial Care into Routine Cancer Care. Journal of Clinical Oncology 30:1154–1159.
Kagawa-Singer, M., et al.
2010 Cancer, Culture, and Health Disparities: Time to Chart a NEW course?. CA: A Cancer Journal for Clinicians 60:12–39.
Kales, H.C., et al.
2005 Effect of Race and Sex on Primary Care Physicians' Diagnosis and Treatment of Late-Life Depression. Journal of the American Geriatrics Society 53:777–784.
Keshet, Y., A. Popper-Giveon, and I. Liberman
2015 Intersectionality and Underrepresentation Among Health Care Workforce: The Case of Arab Physicians in Israel. Israel Journal of Health Policy Research 4:1–13.
Kirmayer, Laurence J., et al.
2003 Cultural Consultation: A Model of Mental Health Service for Multicultural Societies. The Canadian Journal of Psychiatry 48:145–153.
McLoone, J., et al.
2012 When the Risks are High: Psychological Adjustment Among Melanoma Survivors at High Risk of Developing New Primary Disease. Qualitative Health Research 22:1102–1113.
Mitchell, Alex J., et al.
2011 Prevalence of Depression, Anxiety, and Adjustment Disorder in Oncological, Haematological, and Palliative-Care Settings: A Meta-Analysis of 94 Interview-Based Studies. The Lancet Oncology 12:160–174.
Nakash, O., T. Saguy, and I. Levav
2012 The Effect of Social Identities of Service-Users and Clinicians on Mental Health Disparities: A Review of Theory and Facts. Israel Journal of Psychiatry and Related Sciences 49:202–210.
Nakash, O., and Tamar Saguy
2015 Social Identities of Clients and Therapists During the Mental Health Intake Predict Diagnostic Accuracy. Social Psychological and Personality Science 6:1–8.
Nakash, Ora, et al.
2014 Comorbidity of Common Mental Disorders with Cancer and Their Treatment Gap: Findings from the World Mental Health Surveys. Psycho-Oncology 23:40–51.
2013 The Effect of Cancer on Suicide Among Elderly Holocaust Survivors. Suicide and Life-Threatening behavior 43:290–295.
Ndiwane, Abraham N., et al.
2017 Use of Simulation to Integrate Cultural Humility into Advanced Health Assessment for Nurse Practitioner Students. Journal of Nursing Education 56:567–571.
Neville, Helen A., et al.
2013 Color-Blind Racial Ideology: Theory, Training, and Measurement Implications in Psychology. American Psychologist 68:455–466.
Oyserman, Daphna
2011 Culture as Situated Cognition: Cultural Mindsets, Cultural Fluency, and Meaning Making. European Review of Social Psychology 22:164–214.
Palmer, N.R., et al.
2014 Racial and Ethnic Disparities in Patient-Provider Communication, Quality-of-Care Ratings, and Patient Activation Among Long-Term Cancer Survivors. Journal of Clinical Oncology 32:4087–4094.
Plaut, Victoria C., et al.
2018 Do Color Blindness and Multiculturalism Remedy or Foster Discrimination and Racism?. Current Directions in Psychological Science 27:200–206.
Saha, Somnath, Mary Catherine Beach, and Lisa A. Cooper
2008 Patient Centeredness, Cultural Competence and Healthcare Quality. Journal of the National Medical Association 100:1275–1285.
Schrank, B., et al.
2017 Pushing Boundaries-Culture-Sensitive Care in Oncology and Palliative Care: A Qualitative Study. Psychooncology 26:763–769.

Singh, Nirbhay N., Jennifer D. McKay, and Ashvind N. Singh
1999 The Need for Cultural Brokers in Mental Health Services. Journal of Child and Family Studies 8:1–10.
Sleath, B.L., and J.W. Williams
2004 Hispanic Ethnicity, Language, and Depression: Physician-Patient Communication and Patient Use of Alternative Treatments. International Journal of Psychiatry in Medicine 34:235–246.
Sorkin, D.H., et al.
2016 Barriers to Mental Health Care for an Ethnically and Racially Diverse Sample of Older Adults. Journal of the American Geriatrics Society 64:2138–2143.
Sorkin, D.H., H. Nguyen, and Q. Ngo-Metzger
2011 Assessing the Mental Health Needs and Barriers to Care Among a Diverse Sample of Asian American Older Adults. Journal of General Internal Medicine 26:595–602.
Surbone, A.
2006 Cultural Aspects of Communication in Cancer Care. Recent Results in Cancer Research 168:91–104.
Teal, Cayla R., and Richard L. Street
2009 Critical Elements of Culturally Competent Communication in the Medical Encounter: A Review and Model. Social Science and Medicine 68:533–543.
Tervalon, Melanie, and Jann Murray-Garcia
1998 Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. Journal of Health Care for the Poor and Underserved 9:117–125.
Thornton, Rachel L. Johnson, et al.
2011 Patient-Physician Social Concordance, Medical Visit Communication and Patients' Perceptions of Health Care Quality. Patient Education and Counseling 85:e201–e208.
van Ryn, M.
2002 Research on the Provider Contribution to Race/Ethnicity Disparities in Medical Care. Medical Care 40:140–151.
Walker, Jane, et al.
2011 Thoughts of Death and Suicide Reported by Cancer Patients Who Endorsed the "Suicidal Thoughts" Item of the PHQ-9 During Routine Screening for Depression. Psychosomatics 52:424–427.
Wang, J.H., et al.
2012 Physical Distress and Cancer Care Experiences Among Chinese-American and Non-Hispanic White Breast Cancer Survivors. Gynecologic Oncology 124:383–388.
Watts, K.J., et al.
2017 Communicating with Patients from Minority Backgrounds: Individual Challenges Experienced by Oncology Health Professionals. European Journal of Oncology Nursing 26:83–90.