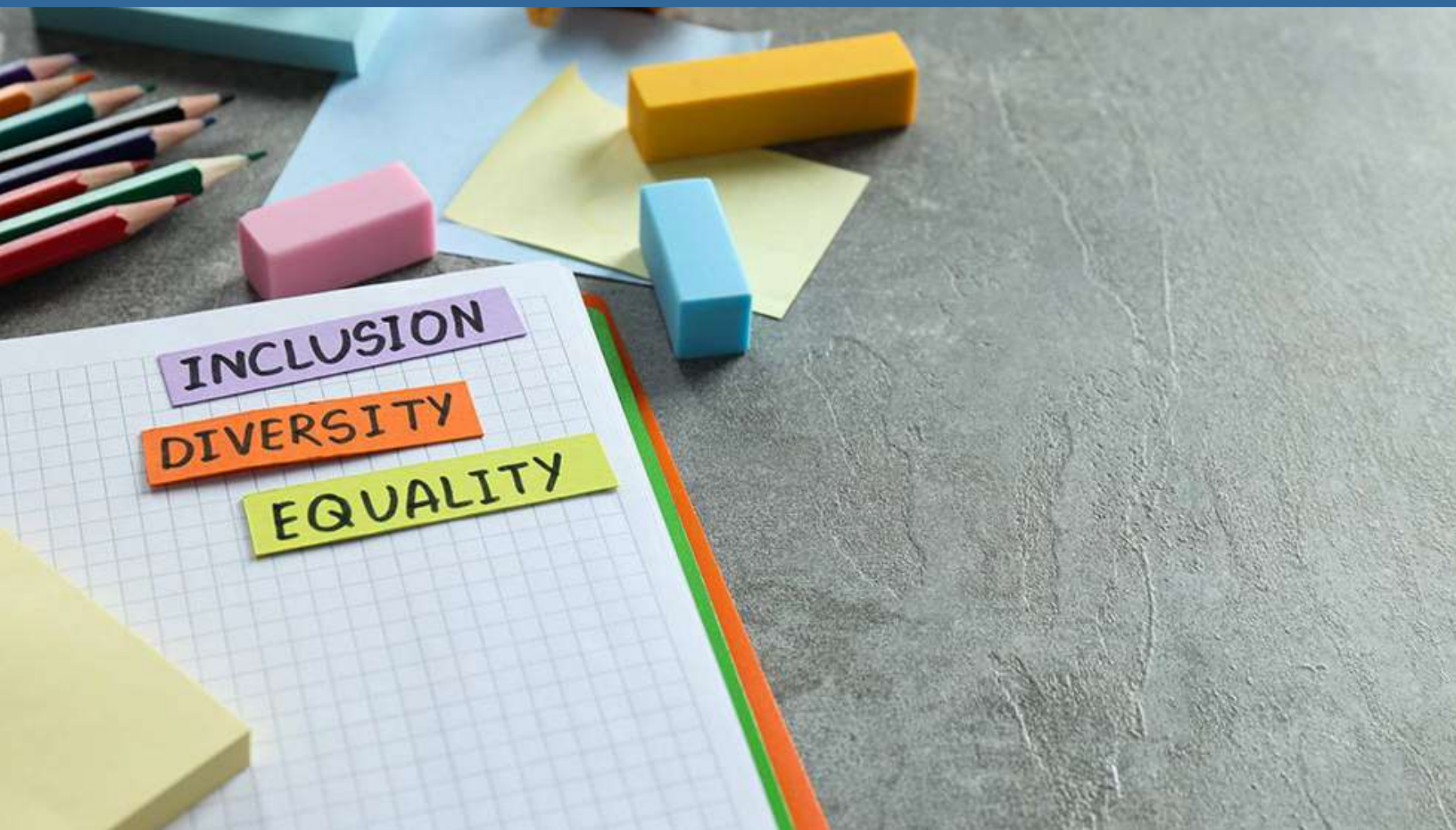
Mindful
Continuing Education

Promoting Inclusivity in Mental Health Practice



Introduction

“Inclusivity in mental health practice refers to the intentional and proactive efforts made by mental health professionals to create an environment that is welcoming, respectful, and responsive to the diverse needs of all individuals seeking mental health support”. This approach recognizes and values differences in race, ethnicity, culture, gender, sexual orientation, socioeconomic status, age, ability, and other aspects of identity. Mental health practitioners must promote inclusivity in mental health practice because inclusivity aligns with ethical principles, ensuring that mental health services are accessible, equitable, and respectful to all individuals, regardless of their background or identity. Inclusivity is crucial for building trust and rapport between mental health practitioners and clients, as individuals are more likely to engage openly in therapy when they feel understood, respected, accepted, and valued.

Cultural identity is vital in determining who we are, what we think, what we eat, the music we listen to, what we believe about family and gender, and how we respond to our environment. One could argue that we are exposed to culture in the womb based on the foods, music, and living conditions the mother experiences and transfers. Even how one is born is influenced by their culture (hospital, home birth, doctor, midwife, etc.). Culture influences the meaning people give to their symptoms and to the cause and implications of the personal difficulties they experience in life (Jones-Smith, 2019). Mental health professionals must consider cultural diversity and inclusivity as essential to socially and ethically responsive quality healthcare.

If a mental health provider is providing services without understanding equity, diversity, and inclusion, there is the potential to cause harm to their client. The harm may be unintentional, but the harmful results of racism, homophobia, or sexism are still felt. The mental health field has historically perpetuated

colonialism and contributed to the institutional barriers faced by people of color. Mainstream psychology has been Eurocentric both in its research and in the workforce (88% of psychologists are white) (Santoro, 2023).

Understanding Diversity in Mental Health

Exploring Diverse Identities

Mental health organizations must actively work to ensure services are equitable, accessible, and inclusive of their communities' diversity. Diversity refers to all the differences between people in how they identify on various grounds, including age, caring responsibilities, disability, gender, sexual orientation, and indigenous, cultural, and socioeconomic backgrounds (Fossey & Palmer, 2021). This is important in the United States as, according to the U.S. Census Bureau, racial and ethnic minority communities makeup about 38% of the United States population and will become the majority nationwide within 30 years. In 2019, one out of ten Americans identify with a racial or ethnic group other than white (Santoro, 2023). The increasing diversity of the United States presents a need for a culturally and linguistically competent behavioral health workforce (HHS, 2019).

Culture shapes every aspect of a client's mental health care, influencing when, where, how, and to whom they share their experiences of illness and suffering, the patterning of symptoms, and the models mental health providers use to interpret and understand symptoms in terms of psychiatric diagnoses. Culture also shapes the clients' perceptions of care, including what types of treatment are acceptable and for how long. This can happen even when clients and providers share similar ethnic or linguistic backgrounds. Culture affects care through other influences on identity, such as gender, race, age, class, occupation, sexual orientation, and religion/spirituality (Aggarwal & Lewis-Fernandez, 2020).

Mental health reform has been working to improve mental health services to ensure that they are equitable, accessible, and inclusive of the diversity of all within the community served. Research shows that people from culturally and linguistically diverse backgrounds experience barriers in accessing and engaging with mental health services. While it is difficult to accurately assess the rate of mental health disorders experienced by culturally diverse groups, the barriers exist and result in delayed treatment, lack of or no treatment, and inadequate services (Fossey & Palmer, 2021).

Race and Ethnicity

Members of racial or ethnic minorities often face additional barriers to accessing mental health care. These barriers include higher levels of race-associated stigma, a lack of culturally skilled mental health providers, and a general distrust of the healthcare system. Within cultural communities, negative beliefs, prejudice, and a lack of information about mental health conditions can discourage individuals from seeking care and adhering to treatment plans. Discriminatory practices and policies within the legal and health systems further perpetuate social inequalities and exacerbate these issues (Funer, 2023).

For example, minority populations have a lower risk of acute episodes of major depressive disorder compared to Caucasian populations, but they are at a higher risk of experiencing chronic and debilitating forms of the disorder (Funer, 2023). Additionally, social and institutional discrimination and oppression, including discriminatory laws, policies, and organizational procedures, arbitrarily limit the rights of certain groups. Historical traumas such as colonialism, racism, and sexism have also adversely affected the mental health of those who experience these forms of discrimination and oppression (Funer, 2023).

Gender and Sexual Orientation

Approximately 3.5% of the U.S. adult population (9 million people) identify as gay, lesbian, or bisexual, and 0.3% as transgender. Around 19 million Americans have engaged in same-sex behaviors, and 25% of the population reports some same-sex attraction. (Mongelli, Georgakopoulos, & Pato, 2020). In the United States, there are contradictory attitudes and behaviors towards sexual minorities. On one hand, there is an increased acceptance of LGBTQ individuals. On the other, political changes have been made that setback LGBTQ rights, including the protection of LGBTQ workers, transgender bathroom protections in public schools, and judicial nominees with anti-LGBTQ platforms.

Therapists should be aware of the following challenges experienced by the LGBTQ population According to Sue et al., 2022), therapists should be aware of the following challenges experienced by the LGBTQ population:

LGBTQ Youth: 80% of LGBTQ youth reported experiencing harassment in school over the past year, 66% reported feeling unsafe because of their sexual or gender orientation, 18% had been physically assaulted in school because of their sexual orientation, and 55% reported cyberbullying. LGBTQ youth are more likely to attempt suicide compared to heterosexual peers. The risk is even higher for Black and Latinx LGBTQ youth. LGBTQ youth have an increased risk for substance use and abuse, especially if they have a history of childhood trauma.

- **LGBTQ Couples and Families:** Approximately 20% of same-sex couples are raising children, and over 6 million children have an LGBTQ parent. Children raised by gay or lesbian parents are as mentally healthy as children with heterosexual parents.
- **Coming out:** The decision to come out can be extremely difficult for some people. It may result in rejection, anger, and grief, but for other people,

coming out results in relief and acceptance. Clients coming out may need extra support, as may parents whose children disclose their sexual orientation.

- **Prejudice, Discrimination, and Misconceptions:** The Pew Research Center found that among LGBT adults, 58% have been subjected to slurs or jokes, 40% were rejected by a family member or close friend after coming out, 30% have been physically assaulted or threatened, 30% have felt unwelcome at a place of worship and 25% have received poor service in a restaurant or other business. LGBTQ people's experiences of prejudice and discrimination can account for an increased risk of anxiety, depression, and substance abuse.
- **Aging:** Due to expected or previous discrimination from health care providers, older LGBTQ people are less likely to seek health care. Older LGBTQ individuals may be fearful of facing prejudice in assisted-living communities.

Socioeconomic Status

There are certain situations that people living in poverty may experience. However, it is important to remember that diverse population groups make up those living in poverty (e.g., someone living in poverty in a rural community has a vastly different life experience than someone living in poverty in an urban community). In 2022, approximately 11.5% of the United States population, or 37.9 million people, lived in poverty (Shrider & Creamer, 2023).

According to (Sue et al., 2022), therapists should have an awareness of the following challenges faced by those living in poverty:

- **Invisibility:** Poor people rarely show up in books or TV shows. When they do, they are often represented as lazy, dysfunctional, promiscuous, or drug-addicted. Those who are homeless on the streets are often removed, relocated, or arrested.
- **Educational Inequities:** 51% of public school students come from low-income homes. 22% of those from low-income families do not graduate from high school, compared to 6% from higher-income families. 40% of low-income students who state they are attending college do not show up in the fall. Low-income students need assistance with the college application, enrollment process, and the complexities of the higher educational system.
- **Judicial System Inequities:** Bail is one example of classist discrimination in the justice system. The poor remain in jail, while the richer people accused of the same crimes go home. Legal aid funding is limited, leaving many poor people lacking adequate representation. Crime rate statistics often focus on theft, burglary, and drug sales and deflect from corporate crime that jeopardizes the American public's well-being.
- **Health Care Inequities:** Poverty increases the risk factors for physical and mental health conditions. People who live in poverty are exposed to numerous stressors, including financial difficulties, discrimination, family conflict, inadequate housing, and living situations with higher exposure to violence and trauma, all of which increase one's risk for developing PTSD, anxiety, depression, and other mental health conditions. Those living in poverty may not seek treatment for their physical or mental health conditions due to lack of transportation, lack of time off from work, and lack of health insurance. Those who live in poverty are at increased risk for heart disease, diabetes, exposure to toxins, cognitive and physical functional decline, and homicide. Approximately 12% of the population does not have

health insurance. This results in people not seeking treatment when their condition can be treated until it escalates into a serious health problem. One study found that 45,000 annual deaths in the United States were due to a lack of health insurance.

- **Environmental Injustice:** Waste disposal, dirty industries, and other polluting operations are more likely to be found in rural and urban areas where poor people and people of color live. Those who live in these pollutant-contaminated hot spots are more likely to suffer from asthma and other pollutant-related diseases and conditions.
- **Classism and Minimum Wage:** The United States society relies on people who work in minimum wage jobs. However, a full-time minimum wage job does not allow a person to exit poverty.

Age

Those over 65 years of age make up 16.2% of the United States population. This population group is growing and is expected to make up 20% by 2030. (Sue et al.,2022). Despite making up such a large percentage of the population, the current social structure is not equipped to properly care for this growing group.

According to (Sue et al., 2022), The following are some considerations for therapists working with aging clients:

- **Physical limitations:** Consideration should be given to the room having adequate light, being free from background noise, and furniture placement for easy room navigation if the client uses any mobility support devices (e.g., wheelchair, walker, cane).

- **Sexual health:** Emotional stressors and physical changes can impact sexual functioning. Therapists should screen for sexual health concerns, provide support for emotional reasons, and encourage clients to talk to their healthcare providers about physical health conditions that may be impacting their sexual health (e.g., difficulties with erections, ejaculation, or lubrication).
- **Ageism:** Negative stereotypes regarding aging can impact how society and mental health providers perceive older adults. This can result in the older person feeling invisible and less valued, leading to lower self-esteem.
- **Mental deterioration:** Normal aging does involve some cognitive slowing (e.g., forgetting someone's name or phone number or misplacing an item). For clients reporting or observing cognitive decline, providers should provide a referral to determine if their difficulties are due to normal aging or if there are more significant losses, such as what comes with dementia or Alzheimer's.
- **Elder abuse and neglect:** Maltreatment of older persons can include neglect and financial, emotional, physical, and sexual abuse; it often goes undetected. Assessment for abuse and neglect can be difficult as the older person may feel ashamed or they may have a dependence on the caregiver.
- **Substance Abuse:** It is estimated that 11% of older adults abuse alcohol or prescription drugs. Occasionally, prescription drug misuse may be due to not understanding the dosing instructions. Other times, substance use is brought on after a loss (e.g., the death of a loved one, retirement issues, physical health concerns, changes in finances).
- **Isolation, Depression, and Suicide:** Social isolation and depression are common complaints among older adults. It is important to acknowledge

that depression is not a normal consequence of aging. Depression does, however, often go unrecognized in older adults and is a significant risk factor for suicide. Social isolation negatively affects all aspects of a person's life and should be assessed early on, and interventions should be implemented to prevent isolation.

Ability

Approximately 56.7 million Americans are living with a disability, half of whom have a disability that severely affects their daily functioning. A disability is a physical or mental impairment that significantly limits one or more life activities of the person. (Centers for Disease Control and Prevention, 2023). The Americans with Disabilities Act prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. It ensures that buildings, facilities, and transit vehicles are accessible and usable by people with disabilities.

According to (Sue et al., 2022), considerations for therapists working with clients with disabilities include:

- Mental health providers must ensure they are providing equal services and not denying treatment to people with disabilities. If a potential client is seeking services outside the provider's area of specialty, they should assist the client with a referral to a qualified provider.
- Offices should be evaluated for barriers to meeting the needs of clients with disabilities (e.g., ramps, room to maneuver around furniture, large-print paperwork, and sign-language interpreters).
- Not all disabilities are visible. Those with a visible disability are more likely to face prejudice and discrimination; accommodation is more likely to be

made. When a person has an invisible disability (e.g., mental health disorders or traumatic brain injury), they are more likely to experience frustration from others; some people may not believe they have a disability and blame them for the behaviors they display.

- The stress and prejudice associated with disabilities increase the risk for mental health conditions and substance abuse problems.
- Life satisfaction ratings tend to be lower among people with disabilities compared to their non-disabled peers. Mental health professionals can help clients and family members obtain technological resources, enhance clients' independent living skills, and advocate for appropriate accommodations in school or work environments.

Other Factors

Other possible social categories that may impact one's ability to access mental health services include religious beliefs, educational attainment, employment, military service, marital status, and parental status.

Recognizing Intersectionality

Intersectionality is the different ways multiple individual characteristics overlap to shape how a person experiences everyday life in the society in which they live. These overlapping characteristics can include race, ethnicity, gender, sexual orientation, socioeconomic status, age, and abilities. Intersectionality recognizes that people can identify with multiple different social inequalities at once that combine to uniquely disadvantage them (Funer, 2023).

Intersectionality is a way to view mental health disparities and inequalities beyond individual-level issues and see that they are also influenced by broader social structures of discrimination, stigma, and oppression, including systemic racism, sexism, homophobia, classism, ageism, and disableism (Funer, 2023). An intersectional view of mental health also recognizes the added disadvantage someone will experience by also having a mental health condition. By understanding intersectional disadvantages, appropriate intervention services can be enacted to reduce mental health disparities.

Intersectionality is useful in describing the complexities of disparities and the effects of stigma and discrimination in different social contexts. By addressing health disparities for multiple disadvantaged individuals, providers can better address the needs of multiple disadvantaged individuals with mental health issues and promote equity in the field of mental health (Funer, 2023).

Examining Mental Health Disparities

Racial and ethnic health disparities in behavioral health continue to persist in the United States despite the implementation of healthcare strategies to address disparities. A national survey of over 200,000 people comparing disparities between Whites, African Americans, and Hispanics reported that there was a 10.8% difference between Black-White and a 10.9% difference in Hispanic-White mental health care. (McGregor, Belton, Henry, Wrenn, & Holden, 2019). Contributing factors to these differences include lower access to mental health care, lower help-seeking for mental health concerns, and a lower likelihood of receiving evidence-based mental health treatments. In addition, racial and ethnic minorities are overrepresented among low socioeconomic populations and experience racism, bias, and cultural mistrust of the healthcare system, all of which place an additional burden on access to care and healthcare outcomes.

Racial and ethnic minorities experience higher rates of cardiovascular disease, diabetes, and cancer, all conditions that are preventable for many and are overrepresented among those with behavioral health conditions (McGregor, Belton, Henry, Wrenn, & Holden, 2019). Both poor behavioral health and preventable physical diseases have similar contributing factors, including inadequate access to healthcare resources, lack of health insurance, limited income, language barriers, transportation barriers, and poor healthcare quality (McGregor, Belton, Henry, Wrenn, & Holden, 2019).

Culturally Competent Communication

Culture influences:

- How direct are we when discussing negative or embarrassing information?
- How open are we to talking about personal problems?
- How formal do we expect interactions with mental health providers to be?
- How important are personal warmth and willingness to engage in small talk with us.

According to (Stubbe, 2020), research has identified five key predictors of culture-related communication problems:

- cultural differences in explanatory models of health and illness,
- differences in cultural values,
- cultural differences in patients' preferences for provider-client relationships,
- racism and perceptual biases,
- linguistic barriers.

All mental health professionals experience implicit bias, the unconscious pre-conceptualization of how one communicates with and treats clients based on their race and ethnicity, age, gender, sexual orientation and identification, class, education, religion, and physical ability. Everyone experiences implicit bias, even those who aspire to have a multicultural orientation and an openness to diversity (Stubbe, 2020).

The U.S. Department of Health and Human Services Office for Minority Health has developed the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The National CLAS Standards were established to help providers deliver effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The 15 CLAS standards can be viewed in Appendix B.

Effective Cross-Cultural Communication

Effective cross-cultural communication involves providing health care information to the individual in a manner they can understand and access to increase their knowledge about the prevention and treatment of their health. The goal is to positively influence the person's health behaviors, and attitudes. When interacting with clients, it is important to consider verbal, nonverbal, and written communication. Beyond language differences, consideration should be given to different dialects or regional variants within the same language, as well as the person's literacy level (HHS, 2024).

- Verbal communication involves sharing information in a one-on-one interaction, usually orally, to achieve a shared meaning.

- Written communication involves using written symbols such as letters, numbers, graphics, and pictures.
- Non-verbal communication involves conveying meaning without words, such as gestures, facial expressions, eye contact, body language, and clothing.

Clients may need language assistance services due to limited English proficiency or literacy or being deaf or hard of hearing. Language assistance services may include interpretation services for oral communication, translation services for written paperwork, a sign language interpreter for those who are deaf, or reading and explaining paperwork verbally to those who struggle with literacy.

Effective communication is important; mental health providers need to be able to communicate effectively with their clients. Research shows clients with unmet communication needs have poorer health outcomes, struggle to follow medical advice, and are less satisfied with the services they receive when compared to people who do not have communication challenges. (HHS, 2024). Safe, effective, and quality care cannot be given if the provider and client do not understand each other. Providers must have an understanding of their client's needs in order to provide quality care and services. Through effective communication, clients can understand their health condition treatment plan and then follow the recommendations (HHS, 2024).

Mental health providers should be aware that even if they speak the same language as their client, the person may not (HHS, 2024)

- Ask questions.
- Request explanations.
- Understand why they are receiving services.

- Understand the next steps for their care.

Active Listening and Empathy

Active listening is listening and responding to the other person in a way that facilitates mutual understanding (Beheshti et al., 2024). There have been some studies that state active listening can be challenging for some mental health professionals. Active listening requires the professional to focus on the emotional and personal aspects of the client's presenting problem. It requires active listening to the client, understanding their emotions and perspectives, and responding in a manner that shows understanding and empathy (Beheshti et al., 2024).

Empathy is the ability to take the other person's perspective during a conversation. Empathy is understanding the person's situation and how it is impacting their feelings. Research shows that providers who are more empathetic are less likely to experience burnout, their clients experience less distress, and are more satisfied with the care they receive (Beheshti et al., 2024).

Empathy enhances the therapeutic bond between the client and the mental health provider. When working with diverse clients, professional are able to be empathetic, which includes the ability to accept and be open to multiple perspectives of personal, societal, and cultural realities. Professionals can achieve this by exploring the impact of cultural differences or diversity issues on the client's problems, goals, and solutions. Empathy can be challenging in multicultural counseling if the provider is unable to identify the personal cultural blinders they hold. For example, some professionals may hold a color-blind racial attitude, meaning race is not a significant factor in one's status and opportunities in society. Those with color-blind attitudes have been shown to have less empathy than providers who are aware of racial factors (Sue et al., 2022).

Language Sensitivity

Acknowledging language barriers and seeking language assistance services for your client improves everyone's communication ability and improves the quality of care and services provided.

Interpretation is the process of rendering a message spoken in one language into one or more other languages (HHS, 2024). Interpretation is for oral or sign messages and requires strong listening and speaking skills. Interpreters help facilitate communication between the client and the mental health professional who do not speak the same language. Interpreters can also facilitate communication between providers and clients who are deaf or hard of hearing by providing sign interpretation (HHS, 2024).

Translation is converting a written text into a corresponding written text in a different language (HHS, 2024). Translation is for written messages and requires strong reading and writing skills. All written materials should be written in plain language (meaning the reader can find what they need, understand what they read, and use what they read to meet their needs). Clients with different levels of reading literacy and health literacy can understand the written materials. Depending on the client population one serves, written materials may need to be translated and provided in multiple languages.

According to (HHS, 2024), when clients and providers have trouble communicating:

- Clients leave feeling unsatisfied about the visit.
- Providers feel they have not delivered the highest quality of care.

- Clients may feel a lack of confidence in what the provider is saying, whether the provider is explaining a diagnosis or the types of health services available.
- Providers might feel as if they are not getting through to their clients.
- Providers might feel frustrated that they are not able to provide the same quality of care to clients with limited English proficiency or those who are deaf or hard of hearing that they provide to other clients.

Additional consideration: Some clients who may need interpretation or translation services may understand English quite well; they simply struggle with communicating in English. Any comments the provider makes to the interpreter may be understood by the client, even if what the provider said is not interpreted.

Non-Verbal Communication

What a person says can be enhanced or negated by their non-verbal communication. Interpreting non-verbal communication can be difficult for several reasons. First, the same nonverbal behavior from one culture may mean something completely different to someone from another culture. Second, nonverbal communication often occurs outside our awareness, but it influences our evaluation and behavior (Sue et al., 2022). The following are some key aspects of non-verbal communication.

Proxemics

Proxemics is the study of the perception and use of personal and interpersonal space. (Sue et al., 2022). In typical U.S. culture, most people become uncomfortable when people stand too close to them. When one's personal space is intruded upon, many people respond with flight, withdrawal, anger, and

conflict. When people feel close to someone else, they tend to allow them to have closer proximity. There are some who view personal space as a sign of status or dominance. Those with greater status and power take up more space (bigger houses, cars, and offices) (Sue et al., 2022).

Different cultures, however, have different distances in what is considered personal space. Many cultures will have conversations in a much closer proximity than is comfortable for many Euro-Americans. Mental health providers should be aware of their clients' cultural values in proximity. It is not uncommon for a therapist to misinterpret a client's proximity as an attempt at intimacy or to step away from a client and have it misinterpreted as aloofness. Personal space factors affect how furniture is placed in offices, where seating is located, and how far apart the therapist and client sit (Sue et al., 2022).

Kinesics

Kinesics is the bodily movements of a person. It includes facial expression, posture, characteristic movement, gestures, and eye contact. An example of kinesics and culture is the gesture of smiling. In American culture, smiling at someone usually means there is a positive regard for the other person. However, in other cultures, it may be interpreted as a weakness, embarrassment, or shyness. In the mental health field, having the ability to make eye contact is an important assessment, but it may not be accurately interpreted if the person is from another culture that may view direct eye contact as a sign of disrespect. There are numerous similar gestures and movements with different meanings throughout cultures (Sue et al., 2022).

Paralanguage

Paralanguage is the vocal cues a person uses to communicate. Examples include the loudness of one's voice, pauses, silences, hesitations, rate of speech, and

inflections. Silences or pauses, while often uncomfortable for Americans, carry different meanings in other cultures. In some, it can be an agreement to what has just been said. In others, it is a sign of respect. In others, it can be a lack of desire to continue the conversation. Behavioral health professionals can explore the meaning of silence so they do not try to fill the silence and prevent their clients from elaborating or avoiding misinterpretation of the silence. Speech volume and directness are also key cultural differences among groups that may be misinterpreted (Sue et al., 2022).

Non-Verbal Communication and Bias

The problem with non-verbal communication is that it tends not to be under conscious control; it operates on a level of the person often being unaware, which makes it difficult to censor or lie about. Non-verbal communication is often more true than the words a person uses. Non-verbal behaviors can offer clues to unconscious biases. This makes it imperative that mental health providers acknowledge and address their personal biases so they do not inadvertently communicate them to their culturally diverse clients. Oftentimes, clients will be able to quickly assess the therapist for biases, and if they appear too great, they will not continue with therapy (Sue et al., 2022).

Tailoring Assessment and Intervention

Cultural Competence in Assessment

Establishing a collaborative mutual partnership with diverse clients requires an open, self-reflective, other-centered approach to understanding and formulating the clients' strengths and difficulties and co-constructing the treatment plan

(Stubbe, 2020). Tips and reflection questions for practicing cultural competence and humility can be found in Appendix A.

A mental health professional can improve their assessment and diagnosis of a client by considering the client's culture and language. Consideration should also be given to assessment methods and tools used, as those may inadvertently be biased because those who typically research, create, and test the tools are from dominant cultural groups. The following chart shows examples of different assessment methods in order to increase the potential for bias.

1	Physiological assessment (use of biological markers)
2	Direct behavioral observations (providers' direct observation of clients' behaviors when completing a given task)
3	Self-monitoring (clients' recording of their own behaviors)
4	Behavioral self-reporting scales (instruments that ask clients to recall and report their own behaviors)
5	Clinical interview (structured interview with a provider)
6	Trait measures (self-report instruments that measure personality traits)
7	Self-report of psychopathology measures (self-report instruments that measure clinical diagnoses, such as the PHQ-9 to identify depression)
8	Projective tests with structured stimuli (tests such as TEMAS, or Tell me a Story Test, which offer structured visual stimulus cards to elicit story responses that can be used to assess psychological state)
9	Projective tests with ambiguous stimuli (tests that elicit story-style responses to gather information about psychological state using unstructured stimuli, such as an ambiguous visual like a Rorschach inkblot)

Cultural contexts and expectations support the clinical interaction for every client, and not just those from underserved minority groups; cultural formulation is an

essential component of any comprehensive mental health assessment (Aggarwal & Lewis-Fernandez, 2020).

The American Psychiatric Association (APA) recognized mental health disorders have a cultural and social context to them and added to the DSM-5 the Cultural Formulation Interview (CFI) to help providers with cultural considerations in their interview, assessment, and diagnoses of clients. The CFI is a 16-question interview with the goal of providing a culturally competent interview that establishes the client's perspective of meanings and expectations of their health, illness, and treatment. The goal of using the CFI is to improve diagnostic accuracy and engage clients in treatment planning. The CFI's questions focus on four domains: the cultural identity of the client, cultural explanations of the client's illness, cultural factors related to the psychosocial environment and levels of functioning, and cultural elements of the relationship between the client and the mental health provider. Information gathered from these four areas helps to support the diagnosis and treatment plan. The CFI also includes instructions for the clinician completing the interview, explaining the type of information that is being sought by the questions being asked (Aggarwal & Lewis-Fernandez, 2020).

The APA recognized five situations in which cultural factors are particularly important when completing an evaluation, and using the CFI would be beneficial. These are:

1. There is difficulty in the diagnostic assessment due to significant differences in culture, religion, or socioeconomic backgrounds between the provider and the client.
2. There is uncertainty between culturally distinctive symptoms and the DSM-5 diagnostic criteria.

3. There is difficulty judging illness severity or impairment. The provider is struggling to understand the level of severity of symptoms the person is indicating they are/ are not experiencing.
4. There is a disagreement between the client and the mental health provider on the treatment of the mental health condition the person is presenting with,
5. The client has limited engagement and compliance with the treatment plan.

The CFI helps explore and address these issues by asking the client about their views of health, illness, and treatment (Aggarwal & Lewis-Fernandez, 2020). See Appendix C for the Cultural Formulation interview.

Recognizing Bias in Diagnosis

Mental health professionals can misinterpret clients' behaviors, symptoms, or responses when they hold biases about certain cultural groups or interpret behaviors that they don't understand as pathological (HHS, 2019). For example:

- A provider with a positive bias about the resilience of African Americans might miss signs of depression in an African American client.
- A provider who doesn't know direct eye contact can be considered rude in Japanese culture and may interpret a lack of eye contact from a Japanese client as a sign of psychopathology.

Mental health providers should be aware that clinical interviews, while considered one of the best practices for psychological assessment, can contain questions or screenings that are culturally biased and may lead to misinterpretation and then misdiagnosis. By understanding cultural differences, providers can avoid labeling

these differences, such as eye contact, speech patterns, dress, self-presentation, supernatural beliefs, and healthy paranoia, as pathological (HHS, 2019).

Diagnosis bias occurs when diagnoses are more accurate for one group of clients than for another (ex., Male vs. Female, Caucasians compared to African-Americans). Diagnoses may be made more or less for one group over another, or it may be that one group of people is more likely to receive incorrect diagnoses or not. Bias in diagnosis may occur due to the provider's bias, bias in the psychological assessment tool, or bias in the diagnostic criteria being used. Historically, African-American and Hispanic clients were more likely to receive inaccurate diagnoses of schizophrenia, while Caucasian clients were more likely to be given accurate diagnoses of major depression or bipolar disorder. Today, the racial group receiving the most accurate diagnoses is Hispanics, followed by Caucasians, and African Americans continue to receive the least accurate diagnoses (Garb, 2022).

Examples of diagnosis bias include:

- Boys are more likely to be diagnosed with ADHD when compared to girls. Research is emerging that supports boys are more likely to be over-diagnosed with ADHD while girls are more likely to be under-diagnosed with ADHD.
- Research supports there is race bias in the diagnosis of adult mental health disorders, including depression, PTSD, and schizophrenia.
- Emerging research states that eating disorders are underdiagnosed among African-American teenagers compared to Caucasian and Hispanic teenagers.

- African-American military veterans are less likely than Caucasian military veterans to receive a diagnosis of PTSD during their Veterans Benefits Administration disability evaluation.

Bias in diagnosis can have serious consequences, such as prescribing medications for a condition the person does not have, not receiving an appropriate therapy approach to treat the person's mental health condition, or financial consequences, such as a veteran not receiving disability they owed (Garb, 2022).

Mental health providers can take steps to reduce bias in their diagnosis. Providers should be mindful of cultural differences in the symptom expression of mental health disorders. For example, research has indicated that there are some differences between how African Americans and Caucasians show and communicate about symptoms of depression. Providers can use symptom checklists to ensure all clients are receiving the same assessment; it can provide additional information, improve communication, and increase a provider's empathy. Screening questionnaires can indicate where additional evaluation may be needed, particularly among people who are more likely to be underdiagnosed (Garb, 2022).

Personalized Treatment Planning for all Professionals

Treatment plans should be client-centered and co-created. This client self-management approach (HHS, 2019)

- Helps clients identify their problems and gives them the tools to decide how to manage their mental health condition.
- Recognizes that clients are the experts on what inspires and motivates them to make changes to improve their health.

- Offers education about the therapeutic process and how therapy aligns with a client's goals.
- Requires that clients participate in creating their treatment plan.

Providers need to approach treatment planning from a place of cultural humility, working collaboratively with their clients and communicating effectively. Providers who are aware of their own cultural backgrounds, recognize the cultural backgrounds of their clients, and acknowledge the values that are implicit in the medical system, are better able to create mutual understanding with their clients and develop culturally appropriate interventions (Ladha et al., 2018).

The LEARN (Listen, Explain, Acknowledge, Recommend, Negotiate) model provides a framework for cross-cultural communication that supports mutual understanding of the client's problem and establishes a co-created treatment plan.

Listen: Assess each client's understanding of their health condition, its causes, and potential treatments. Establish expectations for the appointment and bring an attitude of curiosity and humility to promote trust and understanding.

Explain: Convey your own perceptions of the health condition, keeping in mind that clients may understand health or illness differently based on culture or ethnic background.

Acknowledge: Be respectful when discussing the differences between the client's views and your own. Point out areas of agreement and difference and try to determine whether disparate belief systems may lead to a therapeutic dilemma.

Recommend: Develop and propose a treatment plan to the client (and their family if appropriate).

Negotiate: Reach an agreement on the treatment plan in partnership with the client (and family), incorporating culturally relevant approaches that fit the client's perceptions of health and healing.

Most professional organizations call for culturally responsive clinical practices when working with people from diverse cultural backgrounds. Culturally responsive therapy happens when the client and therapist are of different backgrounds, and the therapist is aware of the significance of their separate cultural stories, has knowledge of the client's culture, and uses culturally appropriate clinical skills while working with the client. Culturally responsive therapy can be used with any theoretical approach (ex., CBT, DBT, FFT) and is not a specific treatment modality of its own. A therapist can not ethically treat someone without taking into consideration cultural influences on the therapeutic relationship (Jones-Smith, 2019).

Integrating Cultural Factors in Interventions

Treatment should be modified as needed to engage the client and to create a setting where treatment is more accessible. Accessibility may mean the location where treatment is engaged (outpatient treatment organization, community center, or in the client's home). Accessibility can also mean modifying the treatment delivery (including family members, modifying materials language to be understood, using cultural or regional expressions, and using culturally relevant examples). Interventions should be modified as needed to make them more culturally appropriate and accessible (HHS, 2019).

The importance of evidence-based practice is becoming increasingly accepted in multicultural counseling. Originally, evidence-based practice focused on research-supported therapies for specific disorders. More recently, the dialogue has expanded to include clinical expertise, including understanding the influence of

individual and cultural differences on treatment and the importance of considering client characteristics and culture (Sue et al., 2022)

Empirically-supported treatment focuses on the working relationship between the therapist and the client and how it is consistently related to treatment outcomes. A number of relationship variables are considered effective and are all factors known to be critical for effective multicultural counseling. According to (Sue et al., 2022), that includes the following:

- the development of a strong therapeutic alliance
- a solid interpersonal bond (i.e., a collaborative, empathetic relationship based on positive regard, respect, warmth, and genuineness)
- effective management of countertransference
- goal consensus

The assumption underlying best practices is that the best research evidence starts with a comprehensive understanding of the client's background and problem and considers which therapeutic approach is best suited to the client and most likely to provide the best outcome. This allows for individualizing therapy with strong consideration of the client's background and characteristics. Best practices emphasize client characteristics, culture, and preferences and the importance of working collaboratively with the client to develop goals and treatment strategies that are mutually agreeable. Because the focus is on the client and the consideration of cultural variables, evidence-based practice sets the stage for a multiculturally sensitive counseling relationship (Sue et al., 2022).

Overcoming Barriers to Inclusivity

While it is important to recognize the culturally diverse backgrounds of the people we serve, one must be careful not to fall into the trap that once one has reached cultural competence. Seeking to reach cultural competence can be problematic in that it can perpetuate stereotypes and contribute to a power imbalance between mental health providers and clients.

Instead of seeking cultural competence, providers should strive for cultural humility. Cultural humility acknowledges that one does not know and is open to learning from one's clients. It is also aware of one's own beliefs, values, and biases and how one's own culture impacts the relationship with one's clients (Lekas et al., 2020).

Identifying and Addressing Stigma

The stigma surrounding mental health care causes delayed treatment, increased morbidity, and decreased quality of life. Stigma impacts the individual, their families, healthcare providers, and communities in the following ways:

Individuals: Stigma can cause fear and avoidance of mental health care, resulting in delays in seeking help, even if the person is in extreme need. Delays in care can result in exacerbated mental health conditions, leading to worse outcomes and reduced quality of life.

Families: Stigma can cause shame and isolation, making seeking support and resources more difficult.

Healthcare Providers: Stigma can lead to burnout and demoralization, reducing the quality of care provided. Stigma can create barriers between providers and

patients, making it difficult to establish a trusting and therapeutic relationship, which is essential for care to be effective.

Communities: Stigma can lead to a misallocation of resources, and mental health services are often underfunded and overlooked (Ahad et al., 2023).

Mental illness stigma across cultures is a significant barrier to mental health care. The stigma can lead to delayed diagnosis and treatment-seeking behaviors, reduced quality of life, and an increased risk of social exclusion and discrimination. In addition, mental illness stigma often intersects with other forms of stigma, such as gender, race, and socioeconomic status, causing even more marginalization of already vulnerable groups. This makes it challenging to provide equitable, culturally sensitive, and effective mental health care to people with mental illness.

Mental illness stigma is common in various cultures, which can impact mental illness diagnosis, treatment, and management. Mental health stigma presents differently across cultures and is influenced by cultural beliefs, attitudes, and values. The stigma surrounding psychiatry and mental health disorders has numerous detrimental effects on individuals and communities, including:

1. Delayed treatment-seeking behavior

   Stigma plays a significant role in delaying treatment-seeking behavior for people struggling with their mental health. The fear of being labeled, ostracized, or misunderstood due to their condition often deters individuals from seeking help promptly. This can lead to symptoms worsening, escalating the condition's severity and making treatment and prospective recovery more challenging. Healthcare delays can also lead to decreased self-esteem and increased depressive symptoms, creating a vicious cycle of self-blame, isolation, and hopelessness. Prolonged untreated mental health issues can further impair a person's functioning in various life domains,

including work, relationships, and self-care, and lower their overall quality of life.

2. Social Isolation and Discrimination

   Stigma can lead to social isolation and discrimination for those affected by mental health issues. One study found that people with mental health disorders often face discrimination in multiple life domains, including employment and interpersonal relationships. The negative stereotypes and misconceptions surrounding mental illness often result in a lack of understanding and empathy from others, leading to social exclusion. People with mental health issues might face discrimination in various aspects of life, including the workplace, where they might encounter bias in hiring, job retention, and career advancement. Discrimination can cause additional strain in personal relationships, as friends and family may distance themselves due to discomfort, fear, or misunderstanding, exacerbating feelings of isolation and loneliness.

3. Reduced Treatment Adherence

   Stigma can lower adherence to mental health treatments. Perceived stigma can predict treatment discontinuation in older adults with depression. People living with mental health conditions may avoid or discontinue treatment due to fear of being identified as a mental health patient. This fear could stem from concerns about the stigma associated with visiting mental health facilities, taking psychiatric medications, or being seen engaging in therapeutic activities. Non-adherence to treatment regimens can lead to suboptimal treatment outcomes, hinder recovery, and increase the risk of relapse or worsening symptoms. Furthermore, stigma can diminish self-efficacy, making individuals less likely to actively engage in their treatment process, which is crucial for successful recovery.

4. Perpetuation of Misconceptions

   Stigmatizing attitudes towards mental illness contribute to the perpetuation of harmful stereotypes and misinformation. Stereotypes such as appearing dangerous, unpredictable, or culpable for their illness can make people with mental illness perceived inaccurately as dangerous or to blame for their condition, both internally and externally. Stereotyping can create a culture of fear, rejection, and discrimination against individuals with mental health conditions. Misconceptions often result in people with mental health issues being perceived inaccurately as dangerous, unpredictable, or responsible for their condition. Misinformation can hinder public understanding and acceptance of mental illness, exacerbating stigma while negatively influencing policy and legislation, leading to inadequate funding and support for mental health services.

5. Influence of Gender on Stigma

   The impact of stigma on individuals with mental illness is known to vary across different social and demographic categories, including gender. Research evidence indicates that the experience of stigma related to mental illness can be significantly different for men and women, and these differences can be further influenced by cultural context.

6. Influence of Culture on Stigma

   The stigma around mental health varies across cultures. Individuals may internalize their mental health issues differently depending on their cultural backgrounds. This internalization impacts a person's self-perception and openness to seeking help. Cultural beliefs play a big role in shaping attitudes about mental health in families. Experiencing shame and blame from one's

family exacerbates the stigma a person will feel about their mental health issues (Ahad et al., 2023).

Tackling Systemic Barriers

There are a number of strategies that can be implemented to combat mental health stigma across cultures. They include:

1. Public Awareness Campaigns

   Awareness campaigns are key to dismantling misconceptions and improving understanding of mental health disorders. Public campaigns can dispel myths, reduce stigma, and encourage empathy towards affected individuals by promoting accurate information about mental illnesses, their prevalence, and the possibilities for recovery.

2. Cultural Competency Training for Providers

   Education providers with knowledge and skills to understand and respect their patients' cultural backgrounds and experiences are critical for reducing stigma in healthcare settings. Providers who lack cultural competence can inadvertently contribute to stigma, discouraging people even more from seeking help. Training improves a provider's understanding of cultural influences on behaviors and choices around health and results in improved communication between provider and client, also reducing perceived stigma.

3. Peer Support Programs

   People with lived experiences of mental health disorders who share their stories can normalize mental health issues and challenge stigma. By providing real-life examples of individuals living with and managing their

mental health disorders, peer-to-peer advocacy programs may debunk myths and reduce the perceived 'otherness' of mental illness.

4. Community-Based Mental Health Services

   Integrating mental health care into primary care and community settings can reduce the stigma associated with seeking psychiatric help. By integrating mental well-being measures along with other routine and standard primary care protocols it leads to mental health care being more accessible and less intimidating, encouraging individuals to seek help when needed.

5. Evidence-Based Approach

   Research shows that evidence-based interventions, including education and contact-based interventions, can be effective at reducing mental health stigma across cultures. Education-based intervention's goal is to increase knowledge and awareness of mental illness and reduce negative stereotypes. They can include workshops, online courses, and media campaigns. Contact-based interventions facilitate engagements between those with mental health diagnoses and members of the general community with the goal of challenging negative attitudes and beliefs (Ahad et al., 2023).

Addressing the stigma around mental health can improve the effectiveness of psychiatric health care. Developing programs and strategies that foster a culture of understanding and acceptance may encourage more people to seek help when they need it, resulting in improved early detection and intervention, which are essential for better outcomes. Challenging and changing stigmatizing attitudes can improve the therapeutic relationship between healthcare providers and patients, leading to more personalized and effective treatment strategies. It is important to

remember that stigma varies across cultures, distinct societal norms, values, and beliefs. Understanding these cultural variations is necessary to develop effective and culturally sensitive interventions (Ahad et al., 2023).

Building Trust in Diverse Communities

Accroding to (Fossey & Palmer, 2021), trust is imperative when working with culturally and linguistically diverse communities. Some research has shown ways to build trust within diverse communities, including:

- Employing peer workers as a way to build trust in a community.
- Having groups co-facilitated by community members with experience in mental health problems encourages trust, safety, and hope that they, too, could be better.
- Taking time to engage community members and having a Community Advisory Board to ensure that trust is built from within the organization.

Perceived trustworthiness includes factors such as sincerity, openness, honesty, and perceived lack of motivation for personal gain. A therapist or organization that is perceived as trustworthy will have more influence over clients and communities than those who are not. Minorities often view mental health professionals as agents of "the establishment." Trust does not come with the role of the therapist but with the behavioral evidence in their work with clients and the community (Sue et al., 2022).

Improving culturally and linguistically diverse community engagement must be built on trust, acknowledging power differentials, confidentiality, and communication. Improving these four aspects has been shown to improve the

quality of relationships between service providers, service users, and communities (Fossey & Palmer, 2021).

Practical Strategies to Foster Inclusivity

Marjadi et al. (2023) recommend twelve practical tips for an inclusive care practice and service delivery that recognizes diversity, intersectionality, and client-centered care. The twelve tips are:

1. **Beware of assumptions and stereotypes:** Providers must avoid assumptions that may limit their ability to have a precise and holistic view of a client's medical and personal background. Unchecked assumptions can become a barrier to seeking services and deteriorate the ability to provide inclusive and patient-centered care.
2. **Replace labels with appropriate terminology:** Best practice terminology is important to patient-centered care. Using a client's preferred language or terminology shows respect.
3. **Use inclusive language:** Language has the power to marginalize and exclude people. Language should be inclusive and respectful without oversimplifying.
4. **Ensure inclusivity in physical space:** Office spaces should accommodate a range of diverse client abilities, including physical, sensory, and cognitive needs, and lead to an improved client experience.
5. **Use inclusive signage:** This may include font size, type, and color on signs. It also includes using easy-to-understand vocabulary and limiting acronyms that may be difficult for people to understand.

6. **Ensure appropriate communication methods:** Effective communication in healthcare is based on two concepts: not making assumptions and asking clients' preferences.
7. **Adopt a strength-based approach:** A strength-based approach acknowledges clients' resilience, knowledge, capacities, strengths, and abilities. It positively impacts service delivery.
8. **Ensure inclusivity in research:** Early in research design, targeted communities and research participant groups should be consulted to accommodate their views.
9. **Expand the scope of inclusive healthcare delivery:** Healthcare programs should assess their services and expand their scope of practice to be more inclusive. Recommendations for inclusive service to diverse groups include removing financial barriers, cultural competence training, representation of minority groups, and explicit inclusion of marginalized individuals.
10. **Advocate for inclusivity:** Advocating for clients' needs to external organizations may be required for more inclusive care.
11. **Self-educate on diversity in all its forms:** Being inclusive to diversity is not an end goal but a commitment to ongoing processes of becoming more inclusive to more diversity.
12. **Build individual and institutional commitments:** For inclusivity to truly be completely implemented, it must be reflected in the organization's commitment to inclusivity. Inclusivity and respect apply to all clients, staff, professionals, visitors, and business partners.

Case Example Questions

The following are questions and case examples that review some of the diversity and inclusion themes previously discussed. Review each question and the vignettes that follow it. Examples provided (HHS, 2019).

1. Which of the following statements reflects cultural and linguistic competency? Why or why not?

    - "Our office is culturally and linguistically competent because Diana, who speaks Spanish, works with most of our Latino clients."
    - "We want to adapt our services to the values and needs of the members of our community. What else can we do?"
    - "We see all of our clients as the same. There's no difference between what our Hispanic and African American clients need."
    - "I don't like seeing those clients because they never get to appointments on time or follow the recommended treatment plan."
    - "Our office is working to ensure we provide written materials in the foreign languages commonly spoken in our area, and we offer interpretation services."

2. Which of the following examples would require you, as a provider, to seek interpretation services? Explain why or why not for each one you checked.

    - Riya and her teenage daughter are natives of India. Hindi is Riya's primary language, while her daughter is bilingual – fluent in Hindi and English. Riya's daughter attended the counseling session to help interpret between her mother and the counselor.

- Kevin is an international student from China who is studying in the United States. His primary language is Mandarin, but he is also proficient in English. He prefers to receive services in Mandarin.
- Denise was born in the United States and speaks nine languages. English is her primary language.
- James was born in the United States and has moderate hearing loss.
- Claudia was raised in Barbados. English is Claudia's primary language, and she speaks it with a Bajan accent.

3. Which of the following examples of screening tools are appropriate? Which are biased? Why?

    - A clinic screens its Spanish-speaking clients, the majority of whom are of Mexican origin, for depression using a Spanish language version of the PHQ-9 that was written and validated in Spain.
    - A psychologist uses the California Psychological Inventory with a client who is a recent immigrant from Thailand and holds a collectivistic worldview. The psychologist finds that the client's scores on some traits are far from the norm.
    - A counselor at a University Health Clinic uses the AUDIT – a provider-administered version of a screening instrument to measure alcohol consumption, drinking behavior, and alcohol-related problems in adolescents and adults – to assess a 20-year-old, white, male, English-speaking client for alcohol abuse.
    - A Peruvian client suffering from susto is screened for psychopathology using the Minnesota Multiphasic Personality Inventory (MMPI).

- A counselor screens a Vietnamese-speaking client who recently immigrated to the United States for depression using the Vietnamese Depression Scale.

4. Part of cultural diversity is recognizing one's own culture and privilege. What privileges do you have?

    - You do not have a foreign accent.
    - You are not followed when you enter a store.
    - You have never gone homeless or hungry for a day or more out of necessity.
    - You don't face catcalls because of your gender.
    - It was assumed from a young age that you would go to college.
    - You can be pretty sure that if you go into a business and ask to speak to the "person in charge," you will be facing a person of your race.
    - You never think twice about calling the police when trouble occurs.
    - You get time off for your religious holidays.
    - You can go to a doctor whenever you need to.
    - You have never been diagnosed as having a physical or mental illness or disability.
    - You were born in the United States.
    - You have never been the only person of your race, gender, socioeconomic status, or sexual orientation in a workplace setting.

5. In what ways do you practice cultural humility?

- I understand my cultural identity.
- I have a secure belief that I can explore different values without losing a sense of integrity.
- I am always open to exploring a client's cultural identity, and I ask questions when I am uncertain.
- I express curiosity and interest about a client's beliefs, values, and worldview.
- I am committed to learning and growing from interactions with individuals whose beliefs, values, and worldviews differ from mine.
- I always pursue further training or seek consultation from experts when needed

Conclusion

Diversity refers to all the differences between people in how they identify on various grounds, including race, ethnicity, culture, gender, sexual orientation, socioeconomic status, age, ability, and other aspects of identity. Members of marginalized groups often face additional barriers to accessing mental health care. Inclusivity in mental health practice refers to the intentional and proactive efforts made by mental health professionals to create an environment that is welcoming, respectful, and responsive to the diverse needs of all individuals seeking mental health support. Mental health professionals must promote inclusivity in mental health practice because inclusivity aligns with ethical principles, ensuring that mental health services are accessible, equitable, and respectful to all individuals, regardless of their background or identity. Inclusive mental health care recognizes

diversity, equity, inclusion, intersectionality, and a strengths-based approach to providing care to one's clients.

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Appendix A: Tips and Reflection Questions for Practicing Cultural Competence and Cultural Humility

Retrieved from Stubbe, D. E. (2020). Practicing cultural competence and cultural humility in the care of diverse patients. *Focus*, *18*(1), 49-51. April, 2024.

1. Get to know your community. Who lives there, and what are the resource disparities in the community? Is there a large immigrant or refugee population? What are the most common ethnicities and languages spoken? What is the climate in the community regarding cultural diversity?
2. Consider whether politics or laws, such as immigration laws or a recent federal government move to eliminate protections in health care for transgender Americans, are adding to the stress of diverse communities.
3. If you, as the physician, are a person of color, consider how that affects your practice and work with diverse patients. If you are European American, reflect on the implicit biases that may affect your practice with diverse patients and theirs with you.
4. Pay attention to office practices: do they enhance an atmosphere of welcoming everyone? Are interpreter services available, if needed?
5. Ask patients by which pronoun they would prefer to be addressed.
6. Use a journal to jot down potential implicit biases and observations about rapport building, for ongoing self-reflection.
7. Don’t assume. Ask the patient about background, practices, religion, and culture to avoid stereotyping.
8. Reassure by words and actions that you are interested in understanding the patient and helping to coconstruct a plan to fit his or her needs. State

upfront that this is a collaborative process and that you welcome input on the process (communicating openly with each other) and the product (treatment plan).

9. Ask directly what the patient wants to achieve with the psychiatric consultation/treatment. This can help identify patient goals and treatment methods.

10. A family genogram may help clarify family dynamics, cultural background, and possible generational trauma.

11. Ask directly about experiences of discrimination, bullying, traumas, or harassment. Are there fears associated with minority status?

12. Identify strengths, interests, and resilience factors.

13. Discuss patient-centered care to determine whether this is understood or if this is an unfamiliar practice. Get patient input about collaborating in health care decisions. For patients who are accustomed to the doctor being the one making all the decisions, consider initiating a request for decisions, even small ones, to reinforce with them that you want to know their preferences and help them become comfortable with making health care decisions and communicating wants and needs.

14. Inquire about what the patient feels would be helpful. Are there cultural practices or herbal remedies that they have already tried—and what was the result? Are there religious, cultural, or individual convictions that affect choice of treatment?

15. Ask during the session whether the patient has any clarification of information that he or she didn't feel the physician appropriately understood. If using an interpreter, make sure that he or she is interpreting

the full discussion (and not summarizing, which loses the nuance and some meaning).

16. After the session, ask the patient if he or she felt understood, if he or she understands the process and if there is anything else he or she would like to add to be better understood.

17. Model construction of the treatment plan by asking about goals and helping the patient consider possible methods of meeting those goals.

18. Clarify the patient's preference for family involvement and, depending on the age and competence of the patient, what information will be communicated to the family.

Appendix B: National Culturally and Linguistically Appropriate Services Standards

Retrieved April 2024. https://thinkculturalhealth.hhs.gov/clas/standards

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Appendix C: Cultural Formulation Interview (CFI)

GUIDE TO INTERVIEWER

INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED***

The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	INTRODUCTION FOR THE INDIVIDUAL: I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM
(Explanatory Model, Level of Functioning

Elicit the individual's view of core problems and key concerns. Focus on the individual's own way of understanding the problem. Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son"). Ask how individual frames the problem for members of the social network. Focus on the aspects of the problem that matter most to the individual.	1. What brings you here today? IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE: People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem? 2. Sometimes, people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them? 3. What troubles you most about your problem?

CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

CAUSES (Explanatory Model, Social Network, Older Adults)

This question indicates the meaning of the condition for the individual, which may be relevant for clinical care. Note that individuals may identify multiple causes, depending on the facet of the problem they are considering. Focus on the views of members of the individual's social network. These may be diverse and vary from the individual's.	4. Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]? PROMPT FURTHER IF REQUIRED: Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes. 5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?

STRESSORS AND SUPPORTS (Social Network, Caregivers, Psychological Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help-Seeking)

Elicit information on the individual's life context, focusing on resources, social supports, and resilience. May also probe other supports (e.g., from co-workers, from participation in religion or spirituality). Focus on stressful aspects of the individual's environment. Can also probe, e.g., relationship problems, difficulties at work or school, or discrimination.	6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others? 7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?

ROLE OF CULTURAL IDENTITY (Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

	Sometimes, aspects of people's background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, or your faith or religion.
Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.	8. For you, what are the most important aspects of your background or identity?
Elicit aspects of identity that make the problem better or worse.	9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).	10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you?
Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).	

CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP SEEKING

SELF-COPING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors)

Clarify self-coping for the problem.	11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?

PAST HELP SEEKING (Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)

Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing). Probe as needed (e.g., "What other sources of help have you used?"). Clarify the individual's experience and regard for previous help.	12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]? PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED: What types of help or treatment were most useful? Not useful?

CULTURAL FACTORS AFFECTING CURRENT HELP SEEKING

PREFERENCES (Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)

Clarify individual's current perceived needs and expectations of help, broadly defined. Probe if individual lists only one source of help (e.g., "What other kinds of help would be useful to you at this time?"). Focus on the views of the social network regarding help seeking.	Now let's talk some more about the help you need. 14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]? 15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?

CLINICIAN-PATIENT RELATIONSHIP (Clinician-Patient Relationship, Older Adults)

Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or cultural differences that may undermine goodwill, communication, or care delivery. Probe details as needed (e.g., “In what way?”). Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.	Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations. 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need?

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