INTRODUCTION

Mental healthcare systems that were originally designed to serve predominantly native-born, English-speaking patients must now meet the needs of patients from many different cultural, linguistic, and socioeconomic backgrounds. The increasing interactions between health providers and ethnically and socially discordant care recipients bring unexpected challenges, with clinicians unprepared to deal with such encounters. With a growing number of mental health intakes being cross-cultural, clinicians vary tremendously in the extent to which they address ethnic and racial differences in clinical practice. Yet mental health providers rarely get trained in communicating essential concepts and information for effective mental healthcare in different languages; working effectively with patients who have limited health literacy; or effectively adapting services for diverse populations. These clinicians face new demands connecting diverse patients with healthcare personnel who may not be accustomed to working with non–English-speaking populations with different customs, values, and experiences. Addressing these challenges may prove critical to determine whether minority patients will enter mental healthcare and remain in care, which is central in addressing disparities. This chapter describes the challenges of conducting the initial mental health interview with multicultural populations and presents recommendations to improve the clinical assessment during the intake process.
The mental health intake is often the first point of contact for patients seeking mental health services. It poses significant challenges to clinicians as they are faced with the need to accomplish multiple goals, including, but not limited to, establishing diagnosis, facilitating rapport, providing psycho-educational tools, and planning treatment. The observations providers make during the intake directly affect patients’ retention in care and guide providers’ decisions regarding treatment planning. These decisions are exceptionally taxing as they are often made under conditions of time pressure and uncertainty. Such conditions are even more pronounced in service delivery for multicultural populations, which are typically in safety net health settings.

Despite growing awareness of the importance of addressing the needs of diverse populations, these patients continue to face barriers even before reaching mental health intakes. Among these barriers are structural factors (e.g., transportation; availability of specialty services); language and literacy (e.g., providers who speak their native language, access to interpreter services); and financial (e.g., insurance, reimbursement) and cultural barriers relating to acceptable norms and perception of mental illness and treatment.

Patients also bring their cultural backgrounds, beliefs, practices, and languages into the mental health intake; these require attention to provide quality care that reduces disparities. Patients and providers may have a different understanding of the etiology of an illness and the acceptable forms of treatment as a result of their cultural background. What patients want from their providers in the mental health intake may vary as a result of their ethnic/racial background.

Communication styles may also differ as a result of the patient’s background. A person’s ethnic and racial background may impact what s/he reports, what the clinician asks him/her to report, and how the clinician interprets the information provided. For example, forms of communicating, such as asking questions, may not be considered appropriate behavior in some cultures. Alegría and colleagues (1) also found that the symptoms patients discussed with their providers during the mental health intake varied as a function of their ethnic and racial background. Exposure to traumatic events was more likely to be discussed with Latino patients, while substance abuse–related symptoms were more likely to be discussed with non-Latino white patients. These differences in assessment appear to be mechanisms leading to diagnostic bias in the clinical encounter.

Language challenges are also detrimental factors in non–English-speaking patients trying to explain their mental health problems. When patients and providers speak the same language, patients have reported better physical and mental health outcomes. Alternately, when patients are not able to communicate in their native language with their providers, they are less likely to adhere to treatment and more likely to dropout of care. Stigmatization of mental healthcare, which is common in many minority populations, can also impede the willingness of these patients to come to care (2). Having “depression” or “mental illness” may be perceived by the patient in a deficit model rather than as a curable and manageable medical condition.

In addition, multicultural patients’ expectation of being stereotyped may lead to mistrust in mental health services (3). For ethnic and racial minority patients, there appears to be a strong distinction between being looked at or looked over as a patient, in
a way that hinders the clinician’s ability to “see” them as a person. Themes of respect and healthy cultural paranoia have been acknowledged as being culturally relevant in the clinical intake and crucial for clinicians to appreciate when working with black patients (4). This requires clinicians to embark on strategies to uncover the uniqueness of a distinct individual and avoid stereotyping these patients. Multicultural patients may feel prejudice or perceive a negative attitude from their provider, reducing the likelihood that these patients will remain in care.

These barriers, in addition to others, will make multicultural patients delay entry into treatment, presenting for care usually in a crisis or emergency state (5). Furthermore, members of minority groups are more likely to dropout after the intake session as compared with their non-Latino white counterparts. For these reasons, the intake session is critical as the entry point to engage these patients in mental healthcare.

### BARRIERS CONFRONTED BY CLINICIANS IN THE CLINICAL INTAKE WITH MULTICULTURAL POPULATIONS

Providers face many institutional and clinical challenges in conducting the mental health intake with diverse minority populations. Time pressure, which has significantly increased in the past two decades under managed care, is one of the most significant institutional barriers providers face. Further, existing research leaves no doubt that providers’ decision-making is complicated by cultural and sociocontextual differences between patients and clinicians (6). Providers are often socialized and trained in making clinical decisions (e.g., the patient’s diagnosis) in a universalistic way, without a clear understanding of the cultural and socio-contextual factors that influence the endorsement of psychiatric symptoms and the diagnosis of illness. Where practice guidelines exist, they often do not include common manifestations of symptoms among ethno-cultural populations. To make diagnostic decisions, providers must collect relevant information related to the particular problem at hand, while organizing this information within a classification system such as that of the *Diagnostic and Statistical Manual* (DSM-IV) (7). However, providers vary widely in the way in which they utilize the DSM-IV to evaluate each of nearly 80 criteria used to establish the presence or absence of psychiatric disorders. In this role, providers are expected to use decisions to estimate the probability of the disorder, while statistically quantifying uncertainties as subjective probabilities in the process of arriving at the correct diagnosis. Additionally, reduced reliability of diagnoses is related to poor knowledge of the criteria by providers, which is often connected with the failure to obtain key information.

Another source of reduced reliability relates to the interpretation of the diagnostic criteria, particularly when clinicians need to decide on the clinically significant characteristics. Given the complexity of such predictions, it is not surprising that to date there are no well-validated algorithms for decisions regarding diagnosis and treatment plans. Under such conditions, clinicians may inadvertently incorporate a prior diagnosis when the decisions are more discretionary than evident. This may lead clinicians to disregard individual data, using what they expect will be the typical symptom presentation and consequently mismatch services to needs.

The quality of the information gathered during the mental health intake is particularly demanding when working with multicultural patients and may vary as a result of the patient’s ethnicity/race. The general literature on disparities shows that symptom presentation varies across racial and ethnic groups and can differ from what most clinicians are trained to expect. For example, recent epidemiological research has
raised questions about the relationship between the endorsement of psychotic symptoms and the diagnosis of psychotic disorders among culturally diverse groups (8). In addition, another study showed that African Americans with posttraumatic stress disorder endorsed more items suggesting psychosis than non-Latino whites, which has led to misdiagnosis (9).

Misdiagnosis can also occur in the form of underdiagnosing when clinicians ignore genuine manifestations of mental illness, misguided by a misinterpretation of cultural sensitivity. Also, clients likely respond to the therapeutic situation in ways that are consistent with their cultural socialization regarding care, but which may be atypical to the expectations of the clinician.

It remains unclear how clinicians organize and weigh the complex information presented to them during the clinical interview to make decisions regarding diagnosis. Recent research suggests that unconscious processes or “deliberation without attention” provide an advantage for making decisions in complex matters (10). Dijksterhuis and colleagues (10) distinguish between conscious thought, which is rule-based and precise, and unconscious thought, in which large amounts of information can be integrated into an evaluative summary judgment in decision-making. In this regard, intuition plays an important role in many clinical decisions. Intuition is characterized as an implicit cognitive process where a decision is made without the explicit knowledge of how it was made. Also, intuition is more likely to play a significant role in decisions that involve uncertainty, such as those faced in clinical practice with multicultural populations. Yet, implicit cognitive processes could have detrimental effects on the care multicultural patients receive, as they are less subject to analysis or supervision and less amenable to change when compared with explicit processes. Providers may not be aware of diagnostic bias or stereotyping, which can guide their implicit clinical decisions with minority patients, thus making it even more difficult to address service disparities in caring for these patients.

The structure of the clinical interview, which is often at the core of the mental health intake, can also directly affect the implicit processes linked to providers’ clinical decisions. Most notable is the tension between structured and unstructured clinical interview models. Structured clinical interviews employ systematic ways of collecting critical information about patients such as evaluation of the specific symptoms and behaviors in a standardized manner. Such systematic ways of collecting information have often been recommended to improve clinical utility by increasing the reliability of the diagnosis and the predictive validity of the assessment. Increasing the reliability of the information gathered by using structured interviews is particularly important when working with minority/multicultural patients, as they can reduce bias and prejudice that have been noted to affect decisions regarding diagnosis and care. However, structured interviews may challenge the existence of open communication between patients and providers, and therefore may hinder the development of a therapeutic alliance. Alternatively, unstructured models of conducting the mental health intake view it as an opportunity to “tell a story” and emphasize the role of good listening and responsiveness on the part of the provider in facilitating good rapport. Open interviews which employ effective listening can allow for contextualizing the patient’s presentation and facilitate “knowing” the patient as an individual person. Such contextualization is pertinent to the initial encounter in which patients often present an intimately complex and unique story (11). Although unstructured interviews can facilitate the development of rapport during the intake, they may challenge the attainment of information required for assessment and decisions regarding diagnosis given the time pressure to which most
intakes are subject. Furthermore, unstructured interviews may lead to greater reliance on stereotypes and bias in these decisions.

### THE ROLE OF STEREOTYPING AND BIAS WHEN PROCESSING MINORITY PATIENT’S CLINICAL INFORMATION

The Institute of Medicine’s (12) analysis highlights the role of stereotyping and biases as contributors to service disparities. In our recent study (1), we observe that during the intake interview providers consistently gathered scarce diagnostic information about the patient’s symptom presentation and tended to base their decisions about mental health diagnosis on generalized statements of illness, patients’ treatment history, and family history of mental health. Moreover, discussion of mental health symptoms varied as a result of the patient’s ethnicity and race. Differential discussion of symptom areas appeared to lead to differential diagnosis and increased likelihood of diagnostic bias. Even with similar information collected during the intake, such as history of abuse, clinicians sometimes weighed the information differently to assign a diagnosis depending on the race/ethnicity of the patient. For example, information about trauma was more likely used to assign a depression diagnoses for Latinos in contrast to non-Latino whites or blacks. However, clinicians appeared to use these shortcuts to maximize the time they could devote to getting to know the patient and engaging her/him in treatment.

Patient’s initiation of information affected providers’ evaluation of the credence and valence of this information (13), as well as their assessment of the rapport during the initial interview. Providers perceived information that was volunteered by patients as more trustworthy and valuable as compared with information they elicited themselves. However, patients’ initiation of information varied depending on whether patients had previous experience in mental health treatment. Novice patients, such as many of the minority populations who are unfamiliar with the expectations of the intake, limited their initiation of diagnostic information. Providers tended to perceive these patients as less engaged and attribute less value to the information that was exchanged during these intake sessions.

Furthermore, unconscious bias on the part of providers has been shown to have significant impact on treatment recommendations for minority patients. For example, Green and his colleagues (14) documented that although clinicians expressed no explicit preference for white versus Black patients, an investigation of their unconscious bias revealed an implicit preference for white patients and an implicit stereotype of Black patients as less cooperative. This unconscious bias directly impacted decisions regarding patient medical care. The likelihood of treating the white patient and not treating the black patients increased as their implicit pro-white bias increased. Bias may also disrupt the formation of the therapeutic alliance, which is fundamental for successful engagement in treatment (15). When significant bias is present in treatment, the result may be alienation and lack of trust compounded by cultural misunderstanding.

Clinicians have frequently described the challenge of collecting, interpreting, and integrating sociocultural information in making decisions about the diagnosis and care of minority patients (16). Most notably, providers have struggled with questions related to the attribution of symptomatology. Deciding what of their patient’s presentation can be attributed to psychopathology, and what can be attributed to sociocultural stressors, such as belonging to a minority status, has been found to be particularly challenging. For example, for some clinicians, certain types of trauma are “in the eye of the beholder”; if it is culturally acceptable for a man to hit his wife, then that may not be
considered as traumatizing (17). However, these assumptions clinicians may make about the greater acceptance of domestic violence as making certain events less traumatizing for certain immigrant groups may be incorrect.

**RECOMMENDATIONS TO IMPROVE THE INTAKE PROCESS WITH CULTURALLY DIVERSE GROUPS**

Despite the numerous challenges clinicians face during the initial intake session, best practices do exist for providing effective services to culturally diverse populations. The Cultural Formulation of Diagnosis (CFD), found in the Appendix IX of the DSM-IV (7), was developed to make the manual more culturally sensitive. The CFD model expands on the guidelines and diagnostic criteria published in DSM-IV to better incorporate cultural contexts and meanings in establishing psychiatric diagnoses for ethnic minorities and diverse populations (18). It assesses five components for formulating diagnosis and treatment needs that include (i) cultural identity (e.g., group affiliation, acculturation); (ii) cultural explanations of the illness; (iii) cultural factors related to the psychosocial environment and levels of functioning (e.g., family and social support); (iv) cultural elements of the clinician-patient relationship; and (v) the overall impact of culture on diagnosis and care.

Kleinman and Benson (19) emphasized that providing care to minority patients is a complex and nuanced process that requires an inquisitive and curious stance, without easily identified parameters to establish when cultural elements explain psychopathology. A balance between an anthropological approach (which emphasizes an effective and attuned listening that views the patient as an individual), and an epidemiological approach (which emphasizes the ability to generalize without stereotyping) may aid in providing quality care to minority patients. Drawing from both theory and empirical research, additional recommendations will be made related to provider awareness of cultural issues and dynamics, contextual and systemic issues and strategies for enhancing the therapeutic alliance.

**PROVIDER AWARENESS OF CULTURAL ISSUES AND DYNAMICS**

When meeting a patient during the intake visit, previous professional and personal encounters help shape the clinician’s initial understanding and assessment of the patient, including his or her cultural, linguistic, and socioeconomic background. Whether this is conceptualized as related to cognitive schemas and scripts, counter transference, or otherwise, such information exists prior to the first meeting and manifests itself during the initial session of treatment. Prior experiences inevitably influence the way each person makes sense of him or herself and how s/he experiences others.

Among the factors impacting the worldview of the clinician (and patient) are the values of the dominant culture. In the United States, beliefs in the importance of individualism and independence, logic and rationality, and success through the achievement of personal goals are embedded in U.S. mainstream culture. The degree to which any clinician may subscribe to these and other ideas informing his or her worldview obviously varies. Such variation appears to be based on racial and ethnic identity, socioeconomic status, gender identity and socialization, religious and spiritual beliefs, and multiple other factors (20). Reliance on such beliefs without reflection increases
dependence on unchallenged personal biases, assuming that one’s own version of “normal” has broader application to the lives of others. Challenging these culturally encapsulated views is often the first step toward providing more effective patient care. Additionally, recognizing how racist attitudes and stereotypes impact one’s thought processes is essential when serving ethnic and racial minority patients. Both race and the racial identity status of the patient have been shown to be significant factors in research investigating therapy process and outcome (21).

Clinicians from dominant social groups (e.g., white, Christian, male) are particularly susceptible to assuming their experiences are generalizable to others based on higher levels of reinforcement received from the larger society. To ensure accurate diagnosis and appropriate treatment, patient behavior needs to be understood within the patients’ cultural context. While interpreting reality through one’s own cultural lens is unavoidable, the mental health profession requires a higher standard. Among the competency areas suggested for practitioners to increase awareness of values and biases are: understanding how one’s cultural background influences attitudes related to psychological processes such as problem-solving, decision-making, and information processing; recognizing the limitations of one’s cultural competency to make appropriate referrals or seek cultural consultation; being cognizant of sources of discomfort related to differences with others; and understanding areas in which one holds privilege and power relative to marginalized groups (22).

In addition to understanding the relevance of cultural variables in one’s own life, it is essential that clinicians are aware of these factors in the lives of the patients they serve. Expanding one’s awareness from the intrapersonal world of the patient to his or her broader context may prove instrumental to arriving at an accurate diagnosis and avoiding either over or underpathologizing diverse patient populations. Recognizing the intergenerational impact of past events, such as slavery, the Shoah (Holocaust), and the destruction of American Indian culture may provide a context for the beliefs, values, and current presentation of patient issues for individuals from communities that have experienced past traumatic events.

Understanding the extent to which racism has been directed toward a patient has been given recent attention in the context of mental health. Carter (23) highlighted the importance of assessing experiences of racism without pathologizing the patient, proposing that such encounters may result in race-based traumatic stress injury. Sue and colleagues (24) have called attention to the shift from direct and explicit acts of racism to subtler, sometimes invisible occurrences. They have proposed that daily indignities experienced by people of color, even if unintentional, may have detrimental consequences to one’s psychological functioning and to the therapeutic alliance in mental health treatment. While individuals vary in the way such acts impact their psychological well-being and functioning, these implications must be considered in the assessment and treatment process. To connect with and accurately conceptualize a patient’s condition, it is necessary to understand current manifestations of racism as well as other forms of oppression that have previously shaped such interactions in clinical encounters.

**CONTEXTUAL CONSIDERATIONS AND SYSTEMIC RECOMMENDATIONS**

Mental health services in the United States are delivered within a specific cultural context. The values, practices, and beliefs held by society are inevitably present in the
clinical intake. As evidenced by the disparities presented earlier in this chapter, racism and discrimination permeate the field of healthcare. Therefore, the intake session represents a critical opportunity for patients to assess their clinicians and the overall mental health treatment process. Recent contributions to the literature (25) have highlighted the importance of systemic factors that enhance effective treatment for culturally diverse communities. Each of the following recommendations holds in common a need for institutional support through clinician advocacy and effective organizational leadership.

A patient’s experience with any mental health system begins by interacting with the larger clinical environment of the organization. For many, a few key factors are worth serious attention: (i) ensuring that signs throughout the building are written in the primary language(s) of patients served; (ii) providing easy access to the facility regardless of physical ability; (iii) hiring receptionists with the language skills and attitude necessary to serve a diverse patient population; (iv) constructing treatment rooms large enough to hold multiple family members whom the patient may wish to include in her or his care; and (v) attending to the cultural relevance of the magazines/literature and artwork in the building. Attention to these issues can be the first steps in building confidence and trust in the treatment process.

Clinic policies related to treatment delivery represent another systemic factor critical to ensuring success in the intake session. Ineffective policies may prove detrimental to even the most well-intentioned practitioner; particularly policies dictating the structure of the intake interview, such as a standardized protocol, that can largely determine the flow of the session. While the advantages to the structured interview have already been discussed, it is important to emphasize that culturally relevant areas of inquiry be included. Time constraints for “completing” the intake are another area often determined by clinic policy. The notion that a patient’s entire clinically relevant history may be gathered in a single session is unworkable in many instances, and flexibility must be offered for extended evaluations in complex cases. At an administrative level, this includes offering clinicians the opportunity to schedule follow-up appointments with such patients in a timely way, as well as making provisions for documenting the extended evaluation. Other policies central to providing competent care during the intake session include requiring collaboration with professional interpreter services for individuals who prefer to conduct the interview in a language not spoken by their provider, ongoing mandatory training in cultural issues for clinic staff, and an organizational commitment to creating a diverse workforce reflective of the patient community.

A final area in which systemic practices have proven important concerns the materials and resources available for patients’ care. In addition to hiring reception personnel with appropriate language proficiency to answer phone calls and providing access to interpreter services based on patient needs and preferences, it is vital that clinically relevant documents be available in multiple languages. The process of obtaining informed consent to treatment is among the key tasks of the intake session, and such consent is most often acquired through written documentation. The need for accurate forms in the patient’s primary language is obvious. Attention must also be placed to providing accessible educational handouts and resources. The use of culturally appropriate assessment instruments is also pertinent to patient services, as many diagnostic tools have not been normed across diverse populations and may prove invalid and unethical for use with certain cultural groups. Further, practitioners must ensure that translated instruments are valid in terms of their linguistic translation as well as being conceptually and functionally equivalent.
Fostering a therapeutic alliance with the multicultural patient is central to the mental health intake. A clinician’s ability to establish an effective rapport has the potential to set the tone for future work and contribute to positive treatment outcomes. For those who enter treatment with uncertainty or skepticism, patient’s expectations are particularly important to address as early as possible. This will be relevant for those patients who had past negative experiences in the mental health system. Spending sufficient time guiding the patient through some of the potentially difficult and/or uncomfortable procedures, such as administering a standardized battery to better assess the diagnostic information, will prove critical. Cultural mistrust related to a specific clinician or the mental health system in general may be accompanied by doubts that a provider can offer effective help or understand their specific situation. Addressing such concerns with openness and cultural humility and showing an interest in learning from and listening to the patient may help establish the necessary affective bonds. Concerns about being stigmatized as a “mental health patient” and fears of breaking cultural norms by talking with others about personal matters may present additional challenges to creating a therapeutic alliance during the intake session. Further, ensuring confidentiality and guaranteeing a nonjudgmental approach is crucial when working with multicultural patients.

Patient-provider communication holds a central role in developing a collaborative therapeutic relationship. Alegria and colleagues (26) have called attention to the necessity of patient activation in the treatment process. To this end, they developed an intervention focused on preparing patients to gather information from providers and formulate questions during appointments. Results showed intervention participants were more likely to attend sessions and follow-up with practitioners than a comparison group. Consistent with these findings, a clinician’s ability to elicit patient questions and concerns, provide information about the treatment process and options available, and facilitate the patient’s participation in actively making decisions in support of her or his goals may prove instrumental to both treatment process and outcome.

Creating a truly collaborative relationship during the intake process requires openness to hearing questions (including those to which answers may be unknown) and a commitment to transparency and authenticity in communication. In addition to spending time obtaining informed consent for treatment, the therapeutic alliance can be enhanced by discussing: (i) the purpose of the intake session; (ii) the process and format of the intake session; (iii) the likelihood that treatment will be of benefit to the patient based on the intake session; (iv) an initial treatment plan; and (v) what patients can expect during the next session if they return to treatment. This information can empower individuals to becoming active participants in their care, particularly for patients who may be unfamiliar with the mental health system.

Through continually enhancing and refining one’s knowledge of various cultural groups is of great importance, this chapter’s emphasis on humility reflects a willingness to listen to and learn from the patient. Setting aside one’s assumptions about the patient and one’s role as “expert” opens the space for an inquiry of cultural variables relevant to the patient’s psychological functioning and well-being. Among those areas to be considered in the assessment process are the patient’s multiple cultural identities, including race and ethnicity, religion and spirituality, socioeconomic status, and relationship status/sexual orientation. Questions related to language and literacy may also prove relevant, including the preferred language spoken during the
interview, at home, in dreams and prayers, and to best communicate emotions. Additional attention must be placed on significant family and/or kinship networks (including extended family, community involvement, and religious community), immigration history and acculturative stress (including pre-migration history, events precipitating immigration, the migration experience, and experience following immigration), definitions of health and illness and sources of strength and resilience. These and other culturally relevant questions have the potential to enhance both the therapeutic alliance and the effectiveness of care provided (27).

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