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Communication study

Patient–clinician ethnic concordance and communication in mental health intake visits

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ABSTRACT

Objective: This study examines how communication patterns vary across racial and ethnic patient–clinician dyads in mental health intake sessions and its relation to continuance in treatment, defined as attending the next scheduled appointment.
Methods: Observational study of communication patterns among ethnically/racially concordant and discordant patient–clinician dyads. Primary analysis included 93 patients with 38 clinicians in race/ethnic concordant and discordant dyads. Communication was coded using the Roter Interaction Analysis System (RIAS) and the Working Alliance Inventory Observer (WAI-O) bond scale; continuance in care was derived from chart reviews.
Results: Latino concordant dyad patients were more verbally dominant ($p < .05$), engaged in more patient-centered communication ($p < .05$) and scored higher on the (WAI-O) bond scale (all $p < .05$) than other groups. Latino patients had higher continuance rates than other patients in models that adjusted for non-communication variables. When communication, global affect, and therapeutic process variables were adjusted for, differences were reversed and white dyad patients had higher continuance in care rates than other dyad patients.
Conclusion: Communication patterns seem to explain the role of ethnic concordance for continuance in care.
Practice implications: Improve intercultural communication in cross cultural encounters appears significant for retaining minorities in care.

1. Introduction

While racial and ethnic disparities in health services have been attributed to a variety of structural and social processes [1], an especially persistent source of disparities in mental health care is the failure of health care clinicians to retain minority patients in treatment after an initial visit [2,3]. Communication during the intake session appears critical to the establishment of a therapeutic relationship and the patient's willingness to remain in care [4,5]. Examining the experience of minority patients, most commonly with a clinician of a different ethnic/racial background, the Commonwealth Fund's *Health Care Quality Survey* found that racial and ethnic minority patients report more communication problems with their clinicians than non-Latino white patients [6]. Among survey participants, 33% of Latinos, 27% of Asian Americans and 23% of African-Americans (as compared to 19% of whites) report dissatisfaction with some aspect of patient–clinician communication.

Research suggests that patient–clinician consultations that are discordant in terms of race, ethnicity, or language are characterized by less participatory decision-making, lower levels of patient satisfaction, and higher rates of miscommunication, even after adjusting for markers of socioeconomic status [7,8]. As a result, it has been postulated that the ethnic/racial matching between clinician and patient may result in superior outcomes [9–13]. Sue and colleagues [12,13] found ethnic/racial matching to be

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associated with longer retention in treatment among multiple minority groups, with the notable exception of African-Americans. This success is attributed to better rapport and comfort between concordant patient–clinician dyads, resulting in greater patient satisfaction [9,14]. Still, a meta-analysis [11] found that ethnic/racial concordance is not a strong predictor of dropout rates (r = .03) or length in treatment (r = .04), and raised questions about the rigor of previous studies [10]. Another study [15] suggested that although patients may prefer racial/ethnic concordance and endorse more positive views of a provider of their race and/or ethnicity, the average effect size (0.09) suggests little to no benefit. Further, evidence in support of concordance by sex or age has generally yielded negative or inconclusive findings [16–18]. Results from Street and colleagues [19] however, suggest that social and emotional factors tied to the patient's sense of shared similarity with a provider in terms of values and beliefs may shed light on discrepant findings to date [19]. Moreover, the construct of homophily is significantly associated with patient-centered communication [19]. These findings lend support to long-standing calls for [9] research examining the role of communication and relationship variables across ethnic/racial groups in clinical visits, the purpose of the current study. Given the documented ethnic/racial disparities in mental health encounters [20], evidence suggests that these factors may hold particular salience for Latino and other minority patients given the critical value they place on interpersonal relationships [21].

Although observational studies of patient-provider interactions and ethnic/racial matching have been largely conducted in primary care, a number of these have addressed adult and pediatric mental health concerns [22–27]. Largely missing from this body of literature are observational studies in psychiatry, though recent exceptions include two studies examining medication management visits for patients with depression or bipolar disease [28,29]. Both report variations in psychiatrists' communication patterns with respect to degree of patient-centeredness and affective tone similar to variations reported among primary care clinicians [30]. To our knowledge, no study has investigated communication during the initial mental health encounter, where the establishment of good rapport and the foundation of a therapeutic relationship succeeds or fails with consequences for patient continuance in care.

The present study describes communication patterns among racially/ethnically concordant and discordant patient–clinician dyads in mental health intake sessions and how it relates to patient continuance in care (defined as attending the next scheduled appointment). We hypothesize that sessions between both white and Latino concordant dyads will be characterized by a stronger working alliance and more patient-centeredness, resulting in higher continuance in care rates than in racially/ethnically discordant dyad sessions.

2. Methods

2.1. Data collection procedures

Data were collected in eight community outpatient clinics in the Northeast US offering mental health and substance treatment to a diverse client population. Study eligibility was limited to individuals receiving outpatient mental health treatment that demonstrated capacity to consent and were non-suicidal or psychotic at enrollment. Exclusion criteria included: screening responses indicative of psychosis or suicidal ideation; and need for interpreter services. See Alegría et al. for a complete description of the study protocol [31].

Of 171 eligible patients approached for study participation, 129 patients participated, 40 patients refused and 2 did not demonstrate capacity to consent. Of the 129, 29 cases were excluded due to poor audio recording quality and one case was excluded because it was the only instance of a concordant African-American clinician-patient dyad. Six mixed ethnicity dyad sessions representing non-Latino white clinicians who spoke Spanish with Latino patients were also excluded from the primary analysis to avoid the possibility of confounding language concordance with other communication-related differences. Results are described in post hoc analysis exploring the role of language in ethnic/race discordant clinician-patient dyads. Ninety-three patient intake sessions with 38 clinicians were included in the primary analysis: 18 self-identified non-Latino white clinicians saw 34 self-identified non-Latino white patients (36.5%) in white concordant dyads; 10 self-identified Latino clinicians saw 24 self-identified Latino patients (25.8%) in Latino concordant dyads; and 19 clinicians of varying self-identified race and ethnicity saw 35 patients of varying self-identified races and ethnicities (37.6%) in mixed dyads.

Clinicians were recruited through informational meetings with study investigators. Among clinician participants, 31% (n = 13) were psychiatrists, 16% (n = 6) were psychologists, 47% (n = 16) were social workers, and 6% (n = 3) were nurses. Patient recruitment was conducted through direct solicitation at the community mental health clinics. Written informed consent was obtained after a complete description of the study was provided. Institutional review boards at each community clinic and at the principal investigator's institution were approved prior to data collection.

All intake sessions were video recorded. Research assistants installed the equipment in the clinician's office prior to the session, started the camera, and left the room. Following the session, all participants completed survey measures and participated in a post-intake qualitative interview (in English or Spanish) regarding presenting problem, perceived rapport and significance of sociocultural factors in patient–clinician interactions.

2.2. Measures

2.2.1. Sociodemographic and clinical measures

Patients reported their gender, age, nativity, employment status, insurance, education, income and time in the US. Intake language of the interview was recorded. Clinicians also reported their gender, age, nativity, and discipline. Patients were assessed for functional limitations with the question: "How many days within the past 30 were you able to work on or carry out your normal activities, but had to cut down on what you did or not get as much done as usual?" Clinicians reported the patient's primary diagnosis after the visit was complete. Patients and clinicians self-reported race and ethnicity using Census categories as: (1) White (not of Latino origin), (2) Black (not of Latino origin), (3) Latino (independent of race), (4) Asian or Pacific Islander, and (5) American Indian or Alaskan Native.

2.2.2. Continuance in care

Continuance in care was defined as returning for the next scheduled visit; appointment keeping was derived from clinical chart or electronic record review by clinic staff.

2.2.3. Working alliance coding of intake videotapes

Working Alliance was scored directly from session videotapes using the Working Alliance Inventory observer form (WAI-O) bond scale [32]. The WAI bond scale is a 12 item 7-point Likert scale instrument (1 = never, 4 = sometimes, and 7 = always) with higher scores indicating a stronger patient–clinician bond. Sample items from the WAI-O include: "There is mutual trust between patient and clinician" and; "There is mutual liking between the patient and clinician." The WAI-O has demonstrated adequate levels of reliability and validity for measuring working alliance [33,34].