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Current Opinion in Psychology

Cultural influences in mental health treatment

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Research on mental health treatments from 2010 to 2015 has continued to highlight the critical role of culture on treatment services, processes, and outcomes for racial/ethnic minority groups. Studies showed that factors such as acculturation and phenotypic appearance were associated with risk for psychopathology. Issues such as face concern and acculturation level were associated with the quality of client–therapist relationships and the amount of information clients disclosed in sessions. While racial/ethnic minority clients generally preferred same-ethnicity therapists, findings showed relatively small effects for racial/ethnic match and positive treatment outcomes. Several studies provided additional evidence for the effectiveness of culturally-adapted, evidence-based treatments compared to non-adapted treatments for minority clients, and more researchers are beginning to delineate the processes involved in making these successful adaptations.

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Current Opinion in Psychology 2016, **8**:131–136

This review comes from a themed issue on **Culture**

Edited by **Michele J Gelfand** and **Yoshihisa Kashima**

For a complete overview see the Issue and the Editorial

Available online 13th October 2015

http://dx.doi.org/10.1016/j.copsyc.2015.10.009

2352-250X/Published by Elsevier Ltd.

Racial/ethnic minority populations continue to grow in the U.S. The most recent U.S. Census showed that Hispanic/Latinos comprised 17.4% of the U.S. population, and Asian Americans experienced the fastest rate of growth — over 40% — from 2000 to 2010 [1]. It is projected that the U.S. will achieve majority–minority status by 2044, and almost 70% of the nation's children will be part of a minority race/ethnic group by 2060 [1]. The diversification of the U.S. is occurring quite rapidly, and mental health researchers are working to respond to the needs of a multicultural society.

Disparities in poor utilization and quality of mental health treatments for African Americans, American Indians, Asian Americans, and Latino/as have been documented for many decades [2,3], and they continue to persist. We review the recent research on cultural issues in mental health and mental health treatments, highlighting the important empirical work that has been conducted in the past five years. We conclude with a discussion of trends and future directions in this area of research.

Cultural variations in mental health disorders, treatment processes, and outcomes

One critical area involves the identification of factors that may influence mental health treatment outcomes for racial/ethnic minority clients. Important differences between racial/ethnic minority and majority groups have been observed in rates of mental health disorders or problems, in perceptions of treatment effectiveness, and in treatment outcomes. This area of research determines how cultural factors can be addressed to decrease disparities in mental health for ethnic minority groups.

Mental health disorders

Despite the fact that ethnic minority clients tend to have similar rates of psychopathology, they utilize mental health services at lower rates compared to Whites and to their level of mental health needs [3]. Asian American patients who utilized inpatient services had more severe psychiatric diagnoses (i.e., schizophrenia, psychotic disorders) compared to White inpatients [4], supporting previous research indicating that distress levels are high by the time Asian clients reach the point of accessing services. Additional studies found that while Asian Americans have low rates of substance abuse relative to other racial/ethnic groups, those who are heavy drinkers are more likely to suffer from mental health problems [5]. Culturally-related factors are often associated with the differing rates of mental health disorders for minority groups. Specifically, Latino adults who were more acculturated to mainstream U.S. culture were at more risk for depression compared to Latino adults who were less acculturated to U.S. culture, suggesting that maintaining cultural ties to one's culture of origin may be protective [6]. Bicultural competence (i.e., the ability to identify and be proficient in the host culture as well in one's culture of origin) also was a protective factor against minority stress. College students with high levels of minority stress (e.g., stress that is experienced by a person who is part of a stigmatized group) were less likely to have depressive symptoms if they had high bicultural competence [7]. Black, Hispanic, and Other (e.g., Asian) adults in a nationally-representative sample were more likely to experience emotional stress from experiences of perceived racism compared to White adults, and this stress was positively associated with physical health problems [8]. Additionally, racial/ethnic minorities' low adherence

in taking antidepressant medications may contribute to poor health outcomes [9].

An emerging and interesting area of research has examined the association between one's phenotypic characteristics (often associated with ethnicity and/or race) and rates of psychopathology. Specifically, first-generation Mexican adolescents (i.e., born outside of the U.S.) and second-generation (i.e., born in the U.S. to immigrant parents) with more indigenous ethnoracial appearances were at lower risk for using alcohol, cigarettes and marijuana, while those with more European appearances were at higher risk for drug use [10•]. However, for third-generation (i.e., U.S.-born parents) Mexican adolescents the pattern of findings was reversed. The authors posit that indigenous ethnoracial features served as a proxy for cultural pride and were more salient for adolescents who were recent immigrants or had closer ties to their Mexican cultures [10•]. Thus, third-generation adolescents who were indigenous in appearance but were more removed from immigration experiences were more likely to feel more distress when they perceived discrimination based on their appearance, placing them at higher risk for substance use. The research underscores how various aspects mapping onto culture, even physical characteristics, can affect mental health problems or outcomes.

Perceptions of mental health and treatments

Recent studies suggest that racial/ethnic minority clients continue to perceive mental health problems differently than members of the majority group, which may influence their help-seeking behavior. Hispanic, Black, and Asian adolescents were more likely than Whites to believe that externalizing behaviors, such as getting into fights, problems with other people, or problems at school, are reasons for receiving mental health treatment [11•]. Conversely, White adolescents were more likely than their minority peers to endorse internalizing problems such as feeling depressed or anxious [11•]. These findings suggest that members of the minority groups may hold certain cultural beliefs or norms (e.g., stigma) associated with mental illness or mental health treatments that influence their recognition of or desire to utilize mental health care. In the case of internalizing problems, there may be different cultural thresholds for the tolerance of personal distress that may then affect one's decision to seek treatment. For example, there is a common Buddhist belief that 'life is suffering.' If suffering (i.e., personal distress) is seen as a natural part of life, this may account for why many East Asians often may not seek treatment of internalizing issues.

Treatment processes and outcomes

Cultural factors that influence treatment processes and outcomes continue to become a main focus of mental health treatment research for ethnic minority clients. Treatment process research focuses on the factors that influence the treatment process, such as client disclosure (i.e., how much clients divulge in therapy) or working alliance (i.e., the relationship between client and therapist). Treatment outcomes research focuses on the outcome of therapies, such as reductions in psychological distress (e.g., reduced depression levels). Research on both treatment processes and outcomes has identified the critical role of face concern. Face is defined as a person's own claims about their social character and integrity, and is part of the roles they carry out as a member of a specific social group [12]. Face concern was negatively associated with disclosure of personal information [13•]. Lower acculturation to U.S. culture also was associated with less disclosure, but this was mediated by face concern [13•]. Other studies provided some clarification for the mixed effects of therapist–client racial/ethnic match on treatment outcomes. Specifically, ethnic minority clients prefer to seen by therapists of the same race/ethnicity and tend to have more confidence in their therapists and their skills [14••,15,16•]. Regardless of race/ethnicity, clients rated their therapists as more supportive if they perceived their therapists to be have similar life experiences, attitudes, values, and personality [15]. This perception was positively linked with working alliance and therapist credibility (i.e., how credible clients perceive their therapists) [15].

Despite client preferences for racial/ethnic match, evidence suggests that ethnic match may not be a strong predictor of positive treatment outcomes [14••]. African American clients were the only minority group where racial/ethnic match appeared to be strongly related to client preference, positive perceptions of therapists, and positive treatment outcomes [14••]. Other than African American clients, the research indicated that racial match may influence treatment processes (e.g., engagement, retention), but not the outcomes of treatment (e.g., reduced distress or symptoms). That is, racial/ethnic match between client and therapist may strengthen or support clients' positive perceptions of their therapists, but other factors (e.g., cultural competence or counseling style of the therapist) may have more direct effects on treatment outcomes.

Therapist factors in treatment processes and outcomes

Several recent studies have examined the influences of therapist characteristics, such as ethnicity, birthplace, and acculturation level on treatment processes and outcomes. Clients and therapists were matched based on their place of birth (i.e., Mexico, Puerto Rico, Cuba, or U.S.) and acculturation level to American and Hispanic cultures [17]. Matches in birthplace and acculturation were associated with increased client participation in treatment and decreased substance use for Hispanic outpatient clients [17]. This research suggests that client–therapist matches on variables related to ethnicity and race such as nativity,