

The Role of Sociocultural Information in Mental Health Intake Sessions

Margarita Alegría, PhD,¹ Arlene Katz, PhD,² Rachel Zack Ishikawa, MPH,³ Yaminette Diaz-Linhart, MSW,⁴ Anne Valentine, MPH,⁵ and Sheri Lapatin, MIA⁵

¹ Center for Multicultural Mental Health Research, Cambridge Health Alliance, Somerville, MA, and Harvard Medical School, Boston, MA, USA

² Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, USA

³ Clark University Psychology Department, Clark University, Worcester, MA, USA

⁴ Boston Medical Center, Boston University School of Medicine, Boston, MA, USA

⁵ Center for Multicultural Mental Health Research, Cambridge Health Alliance, Somerville, MA, USA

ABSTRACT

Background: Clinicians are advised to provide culturally competent care but little is known about how this directive translates into clinical practice. We investigated how this directive was implemented by describing how clinicians utilize sociocultural (SC) information, and how it impacts the clinical encounter.

Method: Data were collected in clinics in the Northeast of the U.S. Clients (N=129) and clinicians (N=47) participated in three components of the study: videotaping of the clinical intake, a qualitative interview, and reporting on sociodemographics. Thematic analysis of interviews was conducted using NVivo7.

Results: Clinicians used sociocultural information to understand clients' clinical presentation; inform diagnosis; differentiate psychopathology from contextual circumstances that influence behavior; create empathy; and individuate clients.

Limitations: Since the study only included data from public clinics, the results may not generalize to other settings.

Conclusions: Integrating SC information appears critical to client engagement and to bonding between client and clinician, particularly for diverse populations utilizing public clinics.

The authors have no conflict of interests to declare.

Funding/Support: The Patient-Provider Encounter Study data used in this analysis was provided by the Advanced Center for Latino and Mental Health Systems Research of the Center for Multicultural Mental Health Research at the Cambridge Health Alliance. This study was supported by the National Institutes of Health (NIH) research grant #1P50MH073469 and was funded by the National Institute of Mental Health (NIMH), and by UPR-CHA Research Center of Excellence: Making a Difference for Latino Health, research grant #P60MD002261, funded by the National Institute on Minority Health and Health Disparities (NIMHD).

INTRODUCTION

The cultural competency movement seeks to help clinicians and mental health organizations meet the needs of a diverse client population (1, 2) by improving their understanding and appreciation of cultural differences. Advocates maintain that culturally competent mental health care may lead to more effective care (3-5) and ameliorate health care disparities (2). Clinicians are advised to consider the social and cultural factors that contribute to their clients' clinical presentation (6), but little is known about how such directives translate into clinical practice. This study aims to answer two related questions: For what purpose do clinicians collect sociocultural (SC) information in the intake interview? And how does this information impact the clinical encounter?

Address for Correspondence: ✉ Margarita Alegría, PhD, Department of Psychiatry, Harvard Medical School and Cambridge Health Alliance, 120 Beacon St., 4th Floor, Somerville, MA, USA 02143 ✉ malegria@charesearch.org

BACKGROUND

Multiple efforts to define and disseminate guidelines for culturally competent mental health care in clinical training programs (7) and practice have been made in the last 20 years (8). The Multicultural Counseling Competencies (9) maintain that clinicians require basic *knowledge, awareness, and skills* (10), a conceptualization that has also been endorsed in the development of more recent frameworks (e.g., 11-14). The American Psychiatric Association's guidelines for cultural formulation advise clinicians to supplement their multiaxial diagnostic assessments with investigation of the cultural aspects of the client's identity and to explore how culture influences diagnosis and care (6, 15).

The role that guidelines play in practice is unclear. Inconsistencies between clinicians' beliefs about the importance of addressing diversity issues and what actually transpires in psychotherapy have been noted (16). Moreover, it has been suggested that some clinicians may question the therapeutic value and/or appropriateness of addressing sociocultural differences with their clients (17). Research examining cultural competency in health care is in its infancy. Methodological limitations abound; yet, early empirical studies are promising, particularly with respect to patient engagement and retention in care (18). Given the scant evidence to support how culturally competent care improves service outcomes, particularly mental health outcomes, clinicians may be uncertain how to put culturally competent care into practice (17, 19).

Nevertheless, a growing body of evidence suggests the importance of addressing diversity issues in psychotherapy as a way to enhance the therapeutic relationship (20) and to accomplish treatment goals (21). Acknowledging the complexity of culture and ethnic/racial identity may result in more accurate diagnosis and treatment (e.g., 12, 22, 23). In particular, clinician-led exploration of trauma with political violence survivors has demonstrated that deliberately attending to trauma helps promote therapeutic goals (24).

Given the critical role of the intake interview in discerning a client's clinical and social situation and treatment goals (20), our study focuses on this session. We posit that demands of the intake (e.g., establishing rapport, preliminary diagnosis, and treatment planning) may increase if there are intercultural client-clinician differences, given potential added challenges such as cultural/language variance and resultant difficulties in

interpretation of symptom probes (21, 25). This augments the likelihood of diagnostic bias among racial and ethnic minority clients (25). The extent to which these demands are affected by clinician-led exploration of patient SC information is poorly understood. Research examining racial-ethnic matching among clinicians and clients as a means of enhancing therapeutic alliance and improving outcomes (e.g., dropout rate, length of treatment, client functioning) has resulted in inconsistent findings (26, 27). Still, the degree of clinicians' cultural sensitivity may be related to greater client self-disclosure (28), suggesting that process variables such as clinician competence, awareness and commitment to diversity issues in therapy is an important area of inquiry (19, 26, 29).

This study offers insight about how clinicians utilize SC information and how discussion of SC information can influence the client-clinician communication. To our knowledge, this is one of the few studies examining such a process in naturalistic settings, to suggest how it may be used by clinicians in cross-cultural mental health care.

METHODS

Data were collected in eight safety-net outpatient clinics in the Northeast U.S. offering mental health and substance treatment services to a diverse client population. See Alegría et al. (25) for a complete description of study protocol. A convenience sample of 47 clinicians (CN) participating in mental health intakes was recruited through introductory informational meetings. The majority were female (66%), predominantly 35-49 years of age (45%), and permanent staff (68%) with more than five years of clinical practice (70%). Twenty-six percent were psychologists; 28% were psychiatrists; 38% were social workers; and 18% were nurses. Approximately 53% of clinicians self-identified as non-Latino whites, while 36% self-identified as Latino, 9% as non-Latino black (African-American or African-Caribbean), and 2% as Asian.

The majority of the 129 clients (PT) were recruited through direct person-to-person solicitation at intake sessions. Of them, 60% were female; 50% were Latino; 39% were non-Latino white, and the remaining 12%, African-American or African-Caribbean. Nearly two-thirds of the sample (65%) completed high school and 45% were employed. Approximately 64% reported a personal income of less than U.S. \$15,000 per year,

and approximately 50% were on Medicaid, the state financed insurance for low income individuals. Data collection complied with human subject protocols at participating clinics and at Cambridge Health Alliance in Somerville, Massachusetts.

Both clients and clinicians participated in three separate components of the study: 1) videotaping of the intake; 2) a post-intake qualitative interview conducted immediately after the session; and 3) completion of sociodemographic and clinical measures. Clinician interviews included questions regarding their understanding of the client's presenting problem, the process of clinical decision-making, perceived rapport, and the role of SC factors in the client's presenting problem. Client interviews included questions about the presenting problem, perceived rapport, and significance of SC factors in the presenting problem. All interviews were conducted by trained research assistants blind to the goals, constructs, and hypotheses of the current study.

QUALITATIVE ANALYSIS

Thematic analysis of the clinician (CN) and client (PT) interviews was conducted using NVivo 7 (30). Analysis procedures followed recommendations by Braun and Clarke (31) for using the full study sample. First, an a-priori codebook was developed, which included eight predetermined conceptual categories based on the study aims. These categories represented "buckets," in so far as they contained general rather than specific themes. The buckets were based on reviews of the literature about mental health intakes, the goals of the study, and questions included in the semi-structured post intake interviews (e.g., clinician decision-making, perceived rapport and references to SC factors).

For this study, 30 case-examples from the original 129 cases were initially selected from the larger Patient Provider Encounter Study (PPES). Half of these cases were racially/ethnically concordant client-clinician dyads and half were racially/ethnically discordant client-clinician dyads to distinguish whether the information collected varied across the two types of dyads. Both matched (n=15) and non-matched (n=15) dyads included 5 Latino, 5 non-Latino white, and 5 black clients each. Cases chosen for the 30 case-examples were selected if either the clinician or client referred to culture, race, ethnicity or religion, and social factors, including age, gender, and social class. Two primary research questions guided the initial analysis of the 30 case-examples: what information gets collected and

how it influences the diagnostic intake process. Coders read the excerpts included in each bucket first, and then organized selected references into sub-categories. Post-intake transcripts were coded by three members of the team to establish reliability and organized under the aforementioned categories. Coders met weekly. When disagreement arose, the research team attempted to identify the source of the discrepancy and coded sections were reviewed again until consensus was reached (24, 32). To examine how using SC data influenced the interactional process between clinician and client in more detail, the research team reviewed in depth four cases from the 30 case-examples. The cases selected included both clinician and client reference to SC factors as playing a specific role in the clinical intake. The cases varied based on ethnic/racial match, with three matches: Latino clinician (CN) /Latino client (PT), black CN/ black PT, Latino CN/Latino PT, and one non-match: white CN/Latino PT. The research team analyzed full transcripts of clinician (CN) and client (PT) post-diagnostic interviews and viewed the tape of the intake session. Data sources were triangulated, systematically comparing and contrasting post-diagnostic interviews of clinicians and clients.

RESULTS

How did clinicians use sociocultural information?

To individuate clients, clinicians asked about a range of SC factors including, but not limited to country of origin, cultural background, experiences of discrimination/racism, ethnicity, family history, immigration history, political factors, religion/spirituality, and trauma. We identified three primary ways in which clinicians use SC information in the intake: 1) to create empathy; 2) to individuate clients; and 3) to understand clinical presentation, inform diagnosis, and enable differentiating psychopathology from contextual circumstances that might influence behavior. Using SC information allowed clinicians to see clients as unique persons and to visualize what matters most to them.

We present the following examples illustrating clinicians' use of SC information in trying to make sense of who the client is as a person, separate from clients' diagnosis and/or clinical presentation. Clinicians described how understanding a client's SC context was instrumental to relational engagement and served as means to create a bond:

Latino clinician (101CN) referring to a Latino client:

“So what really made me feel very connected with him was that, the fact that he’s a very young guy, an immigrant, and fatherless.”

Black clinician (312CN) recounting experience with non-Latino white client: *“... She’s working, she needs a babysitter That’s when I had to try to make decisions as well ... I could be hard-nosed, ‘this is the program you gotta go with it and you just get a babysitter,’ or looking at her as a person who is really striving to do better, can I more or less assist her and kind of work with her? And I felt that was my choice, to work with her.”*

Non-Latino white clinician (301CN) referring to a non-Latino white client: *“Um, she indicated a Roman-Catholic background as far as her church I think it’s important to be able to get some idea of their religious background and current level of spiritual involvement in order to ... utilize that as part of their recovery process.”*

One clinician (305CN) eloquently explained that he explores SC information more explicitly with clients of the same ethnicity or race to avoid the impression that he is making assumptions about them, or that they in turn make assumptions about him.

Black clinician (305CN) referring to intake process: *“When I’m intaking, let’s say an African-American person, male or female, I find it just might be a little bit more difficult ... they have another African American here in front of them ... so they try to impress me or even call me brother or ‘you know what I mean,’ ‘you know where I’m coming from.’ And I’ll say, ‘No, I don’t know where you’re coming from’ ... So this way I feel with, uh, let’s say with a Caucasian, male or female, it’s, they know that I don’t know where they are coming from so now I’m asking. So it’s more, ‘I’m trying to learn something.’ So they’re kind of teaching me, um, ‘Hey, my culture is about this, this is what we do, this is my religion.”*

Familiarity with certain cultural norms, clinical manifestations, or language helped clinicians understand clients’ clinical presentation (105CN) and contextualize their experience in order to better understand what they perceived as normal or abnormal (106CN, 115CN), why their symptoms might present in a certain way, or assign a particular degree of severity (118CN). SC information helped guide case formulations and treatment ideas. SC information that several clinicians identified as important for influencing their perception of clinical presentation included client’s ethnicity (115CN, 408CN), socioeconomic status (106CN, 309CN), political trauma (106CN), immigration status (118CN, 423CN), and family context (309CN). Clinicians also described how SC

factors informed their diagnosis, sometimes (208CN, 420CN) serving to rule out a diagnosis, because the SC context presented justified behavior that could otherwise be seen as pathological.

The following clinician narratives illustrate this theme:

Latino clinician (105CN) referring to her Latina client: *“An oppression in my chest ...’ is a typical way of how they [Latinos] describe anxiety; she also says that she suffers from a lot of headaches and that’s very common in Latina women who are depressed.”*

Latino clinician (118CN) describing his Latino client: *“He was living in a situation where you had to be hypervigilant so it was partly adaptive So, again, in terms of why post-traumatic stress disorder, yes he’s had various exposures to violent situations and of extreme fear and he had comrades or whatever or fellow soldiers that died and he saw people that had experienced ambushes Yet, he doesn’t sound like he had sort of acting out behaviors in terms to manage affect because of his traumatic experience ...”*

Black clinician (208CN) recounting experience with her black client: *“I did ask her, ‘despite all of this, how is your faith’ I forget exactly how she put it, but um, kind of, ‘God walking by her side throughout this entire time and that he’s still there’ and ... [...] Well, I, I viewed that as one of the supports that is very helpful to her in managing her symptoms. Um, rather than um, looking at, looking at it as a sign of pathology.”*

The extent to which clinicians explicitly acknowledge the importance of SC factors in case conceptualization and diagnosis varied greatly within our sample. For some clinicians, SC factors were addressed in a technical, categorical manner to establish the client’s preference for language or to gain information about race, ethnicity, education, and socioeconomic factors. Some clinicians adamantly stated that client SC information did not influence the diagnostic process while others were careful to clarify that even though they make culture-free diagnoses, they do not dismiss cultural information altogether, as it helps in understanding the client’s circumstances. Still others maintained that the link between diagnosis and SC information was situational; some diagnoses had nothing to do with culture, while others depended on examining cultural beliefs or experiences (e.g., what is seen as normal physical abuse in spousal relations) to be properly diagnosed (102CN). Trauma information was particularly salient in linking SC and diagnosis (101CN, 208CN). For example, clinicians stated being more likely

to assign a diagnosis of depression than anxiety in clients with a history of trauma.

Sociocultural information's influence on clinician/client interaction

Transcript passages in each bucket revealed several themes linked to how discussion of SC information influenced the client-clinician interaction during the intake. This included: 1) engagement via mutual understanding and rapport building; 2) enhanced clinical appraisal of the client; 3) clinician self-reflection; and 4) differential diagnoses, including differentiation of symptoms from everyday hardship. To explore how use of SC information influenced the interaction between clinician and client, we next examined four cases in which *both* the clinician and client cited the importance of SC information as part of the intake process.

In the first case, an African American client gives a touching account of the traumatic shift in her life circumstances. She cries as she describes her transition from being a professional to becoming homeless.

Client (208PT): *"It's like my life is completely governed by a system that's outside of my reach. I can't see my children but once a week ... I haven't lost custody ... I don't have them as a result of the depression, the anxiety - I was very paranoid about everything, I was very delusional about things. I just was not in control."*

Rather than initially following up on social factors, the clinician follows her protocol, clarifying past medical history. In response, the client continues to elaborate on the shift in her status. When the clinician acknowledges her suffering and picks up on the importance of her faith, the clinician's understanding of what was significant for the client deepens.

Clinician (208CN): *"[Y]ou never imagined you'd be on the other side. How was your faith?"* Client (208PT): *"It's very helpful because it, like, gives me this understanding that God is present even in what I'm presently dealing with."*

Focusing on spirituality was also critical for the clinician to clarify the client's potential psychotic symptoms and ultimately, ruling out a schizophrenia diagnosis. Rather than looking at her spirituality "as a sign of pathology," the clinician began to see it as a support to overcome adversity. Yet, when asked about the importance of the client's social, racial, and cultural background, this clinician dismisses its influence in the patient's diagnosis. Her primary focus, she maintains, is on "the facts of her symptoms."

In this second case, a Latina clinician (CN105) inter-

twines SC issues throughout the interview and addresses how SC factors affect engagement with her Latina client. The clinician (105) uses SC factors to get to know her patient as an individual. She demonstrates being a "cultural insider," emphasizing words and phrases her patient uses to describe her symptoms. When asked about the use of SC factors, this clinician narrates asking the patient's ethnicity, race, and culture and discussing social and contextual factor as a way to deepen their relationship. In the post diagnostic interview, the clinician feels moved to a stance of advocacy through concern for her client who works in a windowless factory.

Clinician (105CN): *"She's worked for 18 years in the factory. I mean, it's horrible working there. I believe her. She says at the factory ... she doesn't speak English ... so when the alarm goes off she only thinks, 'I don't want to burn inside.' She can't even understand if they're telling her something. ... That's hard, that's very hard ... that factory ... has no windows."*

In the post diagnostic interview, this client echoes this sense of engagement. (105PT): *"... she understood me very well. There is no doubt ... She understood me and made me feel good ..."*

In this third case, a Latino client (101PT) describes how he came to the emergency department of the hospital having difficulty breathing, palpitations and feeling fearful about his health. What he was experiencing was diagnosed as an "ataque de nervios" (a nervous crisis, an idiom of distress) and he was referred to mental health care. The Latino clinician reviewed the emergency department clinician's diagnosis, which was not the client's explanation for what has brought him to the clinic. The client was most "preoccupied with his health" to determine "if I have some physical problem." The tension between what matters most to the client (his physical health) and the clinician's agenda of exploring in detail the "ataque de nervios" (a nervous crisis) is noticeable in the diagnostic interview. As the clinician transitions to engage the client by asking him about his immigration experience, he feels a real connection, and is struck by the client's loneliness, resulting in a diagnosis of depression.

Clinician (101CN): *"... This is an immigrant, so that was the first kind of connection. For me, he is 18 but ... like, for me[he] is a child, I mean he's a young adult, but I felt like a big brother or like a father, an immigrant very alone here."*

In the post diagnostic interview, the client did acknowledge that the clinician "explained things well"

and felt connected to him, *saying “we had good chemistry,”* because the clinician understood his experience in the U.S.

In the diagnostic intake of this fourth case, a Latina client narrates her shift in life circumstances since her diagnosis of diabetes, and her fear that she will share the same fate as her father, who lost a leg to the disease. Once an active, energetic person, she now “wants to be alone.” The non-Latino white clinician (712CN) empathizes that “it is a new experience for you,” which is echoed by the client. Although she acknowledges her depression, her main reason for coming to care was diabetes, which her doctor said “needs to be seen with depression.” When asked what helped inform his diagnosis, the clinician cites the client’s age and culture, and provides a description of how the client’s culture influenced him.

Clinician (712CN): “...[h]er coming from a Latino culture where, uh, it’s patriarchal, and females have less of a role in making money for the family. It’s more accepted for a female to be within the house and taking care of things within the house ... Her role in the house, um, I think, represents the potential for, um, a depressive experience.”

DISCUSSION

Our results clarify the primary uses of SC information in the intake interview: to create empathy; to individuate clients; and to understand clinical presentation so as to inform diagnosis; and differentiate psychopathology from contextual circumstances that might influence behavior. These functions underscore the importance of client SC information in service delivery. Differences between the clinician and client may be surmounted by asking about SC factors. As Lakes et al. recommended for clinicians (22), the integration of the client’s perspective with the clinician’s observations may allow clinicians to entertain the world of their clients. Cardemil and Battle (33) suggested that: “a willingness to engage clients in these (SC) dialogues can promote an environment of trust and understanding that will ultimately help the treatment process” (33, p. 278).

Yet our findings also demonstrate how cultural information can act as a double-edged sword; leading to stereotypes and missed opportunities to explore what most matters to the client (24). Our fourth case of Clinician 712 illustrates how assumptions and stereotyping (e.g., gender roles) can increase the risk of over interpreting SC factors, influencing diagnosis and

treatment approaches. In this case, not acknowledging what was most important to this client (“her diabetes”) was a missed opportunity to explore the traumatic aspects of the illness. The clinician instead bases his diagnosis partly on generalized cultural stereotypes, attributing the client’s depression to her being a middle aged, Latino woman having difficulty doing the housework, keeping her role in that “patriarchal” culture. This is consistent with past literature that has shown that cultural judgments can bias clinicians toward both exaggerating and minimizing psychopathology (34-36), but can also help clinicians understand the subtleties of clinical presentation (23, 37).

Our results also evidence great variance in how clinicians apply this information to their case conceptualizations and diagnoses. Contrary to the findings of Hansen et al. (38), most clinicians did not acknowledge the importance of (SC) factors, but many did introduce multicultural counseling competencies (including *knowledge, awareness and skills*) into practice. Clinicians demonstrated these competencies: they asked questions about SC factors, discussed ethnicity/race and national origin, assumed differences (even if ethnic/racially matched), adapted clinical inquiry to the client’s SC history, avoided assumptions, allowed clients to self-define, and minimized the opportunities for hasty diagnoses. These differences might be due to the types of safety-net clinics included in our study which emphasized culture and context. Adaptations made by these clinics included strategies for enhancing clinic cultural competence, such as adaptation of client materials to Spanish, Haitian Creole and other languages, hiring of non-white staff, and diversity training for clinic staff and clinicians (39). Different results could be evidenced in mainstream clinics in private settings. This represents a limitation of the current study and emphasizes the importance of collecting information in different organizational environments.

Our case presentations also demonstrate how SC factors shape the clinical encounter in a reciprocal manner (40). In certain examples (Client 1) it allowed for cultural brokering, supporting a client amidst adversity and/or sudden shifts in client sense of self. In other cases (Clients 2 and 3) cultural knowledge enhanced the interpretation of what was at stake for the client, creating greater engagement. We see elements of the use of SC information as a supportive tool in the identification of spirituality in Client 1. Lopez and Guarnaccia (41) suggested the importance of identifying such protective factors in the client’s environ-

ment. In all of these cases, integrating an inquiry of SC factors created a shared narrative between clinician and client. Lakes et al. (22), drawing on Mattingly and Lawlor (42) discussed the development of a 'shared narrative' in which client and clinician create meaning about how culture affects the client's life. This narrative is also implicated in culturally-relevant planning for future clinical encounters. We can envision that over the course of treatment this narrative is actually a dynamic one that will change and evolve (22). Just as cultural information may help inform an accurate diagnosis in the initial evaluation, it can influence the course of work with a given client, by providing an "accurate" and shared cultural narrative that is a starting point for ongoing shared planning for treatment.

Given the great variance in how clinicians translated culturally-competent principles, institutions could provide reflective and practical experiences in applying culturally competent care. These approaches might include multicultural supervision (43) and structured education around the principles of multiculturalism (44, 45), beyond teachings of a graduate degree. Additional training efforts could include experiential learning techniques through continuing education (46) and self-assessment tools (47) that facilitate clinician reflection and awareness. Another strategy could promote the creation of organizational guidelines that encourage eliciting and understanding of client cultural practices, family history, language, involvement with host country, context as well as cultural explanations of the client's illness, psychosocial functioning and help-seeking behavior (48).

CONCLUSION

Our four case studies show a mix of sociocultural, physical, and psychological elements addressed by clinician and client to further their understanding and co-construct their care agenda. Our results emphasize how this is a critically important area of focus that affects diagnosis and treatment for multicultural clients and should be an area of ongoing study. It is important to include in practice those structures that can facilitate construction of shared stories to improve client engagement and sense of understanding and prospectively evaluate whether it has an impact in the outcomes of care.

References

1. Costantino G, Malgady RG, Primavera LH. Congruence between culturally competent treatment and cultural needs of older Latinos. *J Consult Clin Psychol* 2009;77:941-949.

2. Mian AI, Al-Mateen CS, Cerda G. Training child and adolescent psychiatrists to be culturally competent. *Child Adolesc Psychiatr Clin North Am* 2010;19:815-831.
3. Añez LM, Pris M, Bedregal L, Davidson L, Grilo C. Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *J Psychiatr Pract* 2005;11:221-230.
4. Rosado JW, Elias MJ. Ecological and psychocultural mediators in the delivery of services for urban, culturally diverse Hispanic clients. *Prof Psychol Res Pr* 1993;24:450-459.
5. Sue S. In search of cultural competence in psychotherapy and counseling. *Am Psychol* 1998;53:440-448.
6. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th ed. Washington, D.C.: American Psychiatric Association, 2000.
7. American Psychological Association: Committee on Accreditation. *Guidelines and principles for accreditation of programs in professional psychology*. Washington, D.C.: American Psychological Association, 2002.
8. American Psychological Association. *Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations*. *Am Psychol* 1993;48:45-48.
9. Sue DW, Arredondo P, McDavis RJ. Multicultural counseling competencies and standards: A call to the profession. *J Couns Dev* 1992;70:477-486.
10. Arrendo PA. Multicultural counseling competencies as tools to address oppression and racism. *J Couns Dev* 1999;77:102-108.
11. Hansen ND, Pepitone-Arreola-Rockwell F, Greene AF. Multicultural competence: Criteria and case examples. *Prof Psychol Res Pr* 2000;31:652-660.
12. Comas-Díaz L. The future of psychotherapy with ethnic minorities. *Psychotherapy (Chic)* 2006;43:436-453.
13. Bernal G, Sáez-Santiago E. Culturally centered psychosocial interventions. *J Community Psychol* 2006;34:121-132.
14. Hays P. Multicultural applications of cognitive-behavioral therapy. *Prof Psychol Res Prac* 1995;26:309-315.
15. Rogler LH, Malgady RC, Constantino C, Blumenthal R. What do culturally sensitive mental health services mean? *Am Psychol* 1987;42:565-570.
16. Zayas LH, Torres LR, Malcolm J, DesRosiers FS. Clinicians' definitions of ethnically sensitive therapy. *Prof Psychol Res Pr* 1996;27:78-82.
17. La Roche M, Maxie A. Ten considerations in addressing cultural differences in psychotherapy. *Prof Psychol Res Pr* 2003;34:180-186.
18. Goode TD, Dunne MC, Bronheim SM. The Evidence base for cultural and linguistic competency in health care. Georgetown University: National Center for Cultural Competence, Center for Child and Human Development; 2006, October [cited 2011 May 3]. Available from: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultringuisticcomp_962.pdf
19. Sue S. In defense of cultural competency in psychotherapy and treatment. *Am Psychol* 2003;58:964-970.
20. Sommers-Flanagan J, Sommers-Flanagan, R. *Clinical interviewing*, 3rd ed. Hoboken, N.J.: John Wiley and Sons, 2002.
21. Vasquez MJT. Cultural difference and the therapeutic alliance: An evidence-based analysis. *Am Psychol* 2007;62:878-885.
22. Lakes K, López SR, Garro LC. Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. *Psychotherapy (Chic)* 2006;43:380-396.
23. Lewis-Fernandez R, Guarnaccia PJ, Martínez IE, Salmán E, Schmidt A, Liebowitz M. Comparative phenomenology of ataques de nervios, panic attacks, and panic disorder. *Cult Med Psychiatry* 2002;26:199-123.
24. Katz AM, Alegria M. The clinical encounter as local moral world: Shifts of assumptions and transformation in relational context. *Soc Sci Med* 2009;68:1238-1246.
25. Alegria M, Nakash O, Lapatín S, Oddo V, Gao S, Lin J, et al. How missing information in diagnosis can lead to disparities in the clinical encounter. *J Public Health Manag Pract* 2008;14 Suppl:S26-35.
26. Karlsson R. Ethnic matching between therapist and patient in psychotherapy:

- An overview of findings, together with methodological and conceptual issues. *Cultur Divers Ethnic Minor Psychol* 2005;11:113-129.
27. Maramba GG, Hall GC. Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultur Divers Ethnic Minor Psychol* 2002;8:290-297.
 28. Fuertes JF, Bartolomeo M, Nichols CM. Future research on counselor multicultural competencies. *J Multicult Couns Devel* 2001;29:3-12.
 29. Gim RH, Atkinson DR, Kim SJ. Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. *J Couns Psychol* 1991;38:57-62.
 30. NVivo 7. Version 4. Qualitative Solutions Research International Pty Ltd. 1998.
 31. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77-101.
 32. Hill CE, Knox S, Thompson BJ, Williams EN, Hess SA, Ladany N. Consensual qualitative research: An update. *J Couns Psychol* 2005;52:196-195.
 33. Cardemil EV, Battle CL. Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Prof Psychol Res Pr* 2003;34:278-286.
 34. López SR. Patient variable biases in clinical judgment: Conceptual overview and methodological considerations. *Psychol Bull* 1989;106:184-203.
 35. Comas-Díaz L. The future of psychotherapy with ethnic minorities. *Psychotherapy (Chic)* 1992;29:88-94.
 36. Pinderhughes E. Understanding race, ethnicity, and power: The key to efficacy in clinical practice. New York, N.Y.: Simon and Schuster, 1989.
 37. Guarnaccia P, Pincay I, Shrout P, Alegría M, Lewis-Fernandez R, Canino G. Assessing diversity among Latinos: Results from the NLAAS. *Hisp J Behav Sci* 2007;29:510-534.
 38. Hansen ND, Randazzo KV, Schwartz A, Marshall M, Kalis D, Frazier R, et al. Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Prof Psychol Res* 2006;37:66-74.
 39. Paez KA, Allen JK, Carson KA, Cooper LA. Provider and clinic cultural competence in a primary care setting. *Soc Sci Med* 2008;66:1204-1216.
 40. Park M, Chesla CA, Rehm RS, Chun KM. Working with culture: Culturally appropriate mental health care for Asian Americans. *J Adv Nurs* 2011;67:2373-2382.
 41. López SR, Guarnaccia PJ. Cultural psychopathology: Uncovering the social world of mental illness. *Ann Rev Psychol* 2000;51:571-598.
 42. Mattingly C, Lawlor M. The fragility of healing. *Am Anthropol* 2001;29: 30-57.
 43. Garrett MT, Borders LDA, Crutchfield LB, Torres-Rivera E, Brotherton D, Curtis R. Multicultural superVISION: A paradigm of cultural responsiveness for supervisors. *J Multicult Couns Devel* 2001;29:147-158
 44. Preli R, Bernard JM. Making multiculturalism relevant for majority culture graduate students. *J Marital Fam Ther* 1993;19:5-16.
 45. Sue S, Terry A. The matrix model for clinical psychology: A contextual approach. *J Clin Psychol* 2005;61:1131-1134.
 46. Delphin ME, Rowe M. Continuing education in cultural competence for community mental health practitioners. *Prof Psychol Res Pr* 2008;39:182-191.
 47. National Center for Cultural Competence. Cultural competence health practitioner assessment (CCHPA) tool. Washington, DC; 2004 [cited 2011 July 27]. Available from: <https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?formID=277>.
 48. Mezzich JE, Caracci G, Fabrega H, Kirmayer LJ. Cultural formulation guidelines. *Transcult Psychiatry* 2009;46:383.



ACCULTURATIVE STRESS & COPING WITH CULTURAL TRANSITION

1st INTERNATIONAL CONFERENCE ON
**CULTURAL PSYCHIATRY
 IN MEDITERRANEAN
 COUNTRIES**

Tel Aviv, Israel
 5-7 November, 2012

