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A Systematic Review of Effective Intercultural Communication in Mental Health

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Abstract

Purpose of the Research: Effective intercultural communication between patients and clinicians is essential for the delivery of high quality health care. To date, there has been no systematic assessment of empirical literature on effective communication within a mental health context, despite theoretical models purporting certain criteria make health communications more effective. The current research aims to determine factors which aid or hinder communication effectiveness in such a context, and to see whether the literature supports Teal and Street's (2009) theoretical model specifically. Additionally, the review considered the role of language disparity between patients and clinicians within the mental health context.

Method: Electronic databases Medline, Psych Info and Web of Science were searched using an optomised search strategy in June 2014. Studies were considered where intercultural communication between a clinician and patient was a primary focus. To meet inclusion the papers needed to be empirical in nature, written in English, peer-reviewed and of sound quality. Data relating to the study type and analysis used, characteristics of participants (both patients and clinicians), cultural and communication information were extracted.

Results: Eight papers were included in the final review. The results largely support Teal and Street's model and highlight that nonverbal and verbal behaviour skills, recognition of cultural differences, incorporating cultural knowledge, alongside negotiation and collaboration with patients and family members, all aid in effective communication. Additionally, language barriers were found to pose a significant barrier to communication. The quantity of current literature investigating the effectiveness of intercultural communication specifically within a mental health setting is limited, highlighting the need for further investigation.

Key words: Intercultural communication; Effective communication; Cross-cultural; Mental health services; Patient-clinician relations

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INTRODUCTION

The quality of care provided to ethnic minority patients is often below the standard provided to patients from the cultural majority (Qureshi, Collazos, Ramos, & Casas, 2008). Poorer health care access, utilization and treatment of ethnic minorities are well documented (Archie et al., 2010; Bird et al., 2008; Kirmayer, et al., 2007), with culture shown to influence help seeking and care pathways within a therapeutic setting (Ayonrinde, 2003). Barriers to health communication contribute significantly to poorer access to care, affect the quality of care and negatively impact on health outcomes (Calderon & Beltran, 2004).

Studies show that the communication within a health care setting is poorer when the interaction is intercultural. Communication is deemed intercultural whenever cultural differences exist between the patient and clinician. These differences may be seen both between and within cultural groups, defined by factors such as ethnicity, language, gender or socioeconomic status (Teal & Street, 2009). Research highlights that the degree of time spent in consultation, the content of conversation and

the emotional responses of both parties differs between culturally diverse and culturally similar patient-clinician interactions (Butow et al., 2011; Cooper et al., 2003; Schouten et al., 2007). Doctors also ignore a higher proportion of communication cues when in consultation with a patient from a different ethnic background (Butow et al., 2011).

An understanding of the factors that make communication more effective generally within a health care setting is essential to ensure effective intercultural communication between patients and clinicians and the delivery of high quality health care. Teal and Street (2009) define a model of cultural competency, which proposes certain behavioural strategies or specific skills enhance the effectiveness of communication in encounters where the patient and practitioner are culturally different. These include (i) non-verbal skills, (ii) verbal behaviour skills, (iii) recognition of potential cultural differences, (iv) incorporation and adaptation to cultural knowledge, and (v) negotiation and collaboration. The view that greater levels of cross-cultural competency allow for better management and treatment within health care, is supported within the current health literature (Costantino, Malgady, & Primavera, 2009; Moffic, 1983; Seeleman, Suurmond, & Stronks, 2009). However, the vast majority of research into cultural competency to date has been developed from the perspective of the health care provider (Wiebe & Young, 2011), whereas Teal and Street (2009) have uniquely provided a model which is patient-focused.

Whilst a strength of Teal and Street's (2009) model is its application across all areas of health communication, including the therapeutic relationship, assessment and treatment, the model has yet to be explicitly tested in regards to the skills actively used within intercultural communication. An analysis of the current empirical literature may well determine whether the theoretical criteria outlined in the model are associated with effective communication. A systematic review of the extant literature can also shed light on other factors critical to effective intercultural communication. For example, the model has yet to be applied to cross-cultural encounters where language differences are present, and the impact that linguistic differences place on intercultural communication is unclear. Current literature highlights that the use of interpreter services significantly impacts the degree and rate of service use (Minas, Stuart, & Klimidis, 1994; Ziguras, Klimidis, Lewis, & Stuart, 2003) and medication compliance (Gilmer et al., 2009) in a mental health setting; whilst lack of services leads to an overreliance on family members in health treatment (Garrett, Dickson, & Whelan, 2008; Hoye & Severinsson, 2010). These studies highlight that the use of interpreter services may aid in effective communication, however the magnitude of this effect for both patients and clinicians has not yet been reported.

Cultural and linguistic factors are particularly significant in altering dimensions of the clinician-patient interactions and communication within a mental health care setting. Patients' understanding of mental distress is related to wider cultural beliefs and practices, influencing what treatments are deemed appropriate (McCabe & Priebe, 2004). Moreover, cultural differences in communicating treatment needs may hinder the development of an effective therapeutic alliance between patients and therapists (Collins, Mathura, & Risher, 1984; Qureshi, & Collazos, 2011) and have been shown to impact on assessment, diagnosis and treatment (Chung & Singer, 1995; Kirmayer, 2001). A mental health focus is also important, as ethnic minority patients are particularly at risk of developing acute mental illness. Higher hospital admission rates, greater treatment non-adherence and dissatisfaction with services all exist within ethnic minority mental health patient populations (McCabe & Priebe, 2004). However, little research has assessed the characteristics and outcomes of effective communication within a mental health setting

Given the significant risk ethnic-minority status appears to confer on mental distress, appropriate treatment, medication adherence and service satisfaction, further investigation of how the effectiveness of intercultural clinician-patient interactions may be improved, can potentially minimise this risk. A synthesis of this research may well identify the range of barriers to effective communication as well as those communication techniques found to be effective, and potentially aid in the further development of culturally appropriate tools and practices. Moreover, given the clinician centred approach of previous literature, it is worthwhile to assess research from both the patient and clinician perspective.

The current review aims to systematically assess the empirical literature describing the effectiveness of patient-clinician cross-cultural communication within a mental health setting. Teal and Street's (2009) model outlines a theoretical framework for factors which may increase the effectiveness of communication within intercultural health settings generally. An analysis as to whether the empirical literature supports this model, within a mental health context specifically, will assist in determining the model's utility. In order to fully analyse cross-cultural communications, both barriers and factors thought to aid the communication process, from both the patient and clinician perspective, will be included. Additionally, literature will be included where there is language discordance between the clinician and patient, in order to further determine how language differences impact on communication between clinicians and patients. These further analyses will serve to potentially add to the model developed by Teal and Street.

1. METHOD

1.1 Inclusion Criteria

The systematic review considered all studies where intercultural communication between a clinician and patient was a primary focus. To meet inclusion criteria, the papers needed to be empirical in nature, written in English, peer-reviewed and of sound quality, assessed through a validated quality assessment tool. Adult participants were considered if they were a patient or a clinician within a mental health setting (any setting in which there was a mental health focus including hospitals, clinics, private practices etc.). Participants were included if the communication between the patient and clinician was intercultural, that is both parties were recognised to come from different cultural or ethnic backgrounds. Outcome measures included all factors that were reported to aid or hinder effective communication. Both verbal and nonverbal communication modalities were included, in keeping with communication as defined by Teal and Street (2009).

1.2 Literature Search

Using an optimised search strategy (Wilczynski, Haynes, & Hedges, 2006) a comprehensive literature search was performed in June 2014. Suitable studies were identified through the searching of electronic databases Medline (1950- present), PsychInfo (1806- present) and Web of Science (1956- present), and the screening of relevant reference lists. An explorative approach was taken, whereby search terms were added or omitted dependent on the relevance and extent of literature that was generated. The following search terms were used as they mapped onto specific keywords utilised by each of the electronic database: depression or mental disorder; bicultural; intercultural; multicultural; cross-cultural; interpreter; interpreting; cultural sensitivity; cultural competency; patient-physician relations; mental health services; health care services; health care delivery; health care administration; health care utilization; and communication. The specific terms outlined in Teal and Street's (2009) model, such as nonverbal behaviour, verbal behaviour and cultural knowledge, were omitted as they limited the scope of literature generated. In this way the results could include papers that considered a broader range of factors than those contained in the model.

The search of electronic databases and relevant reference lists identified 896 potentially relevant articles after the deletion of duplicates (see Figure 1). All titles and abstracts were screened, and 859 articles were excluded as the focus was not intercultural, communication, or clinician-patient interaction based; they were not empirical studies; there was no focus on mental health; they were not written in English; or the treatment population was not adult. To ensure reliability a second reviewer was given a selection of 100 titles and abstracts from the initial 896 articles, and asked to indicate the articles eligibility for inclusion within the review. Inter-rater reliability of the selection of articles based on titles and abstracts was 100% accuracy. The full text of the remaining 37 articles was examined in more detail; a further 29 articles did not meet the inclusion criteria as they contained no empirical data.

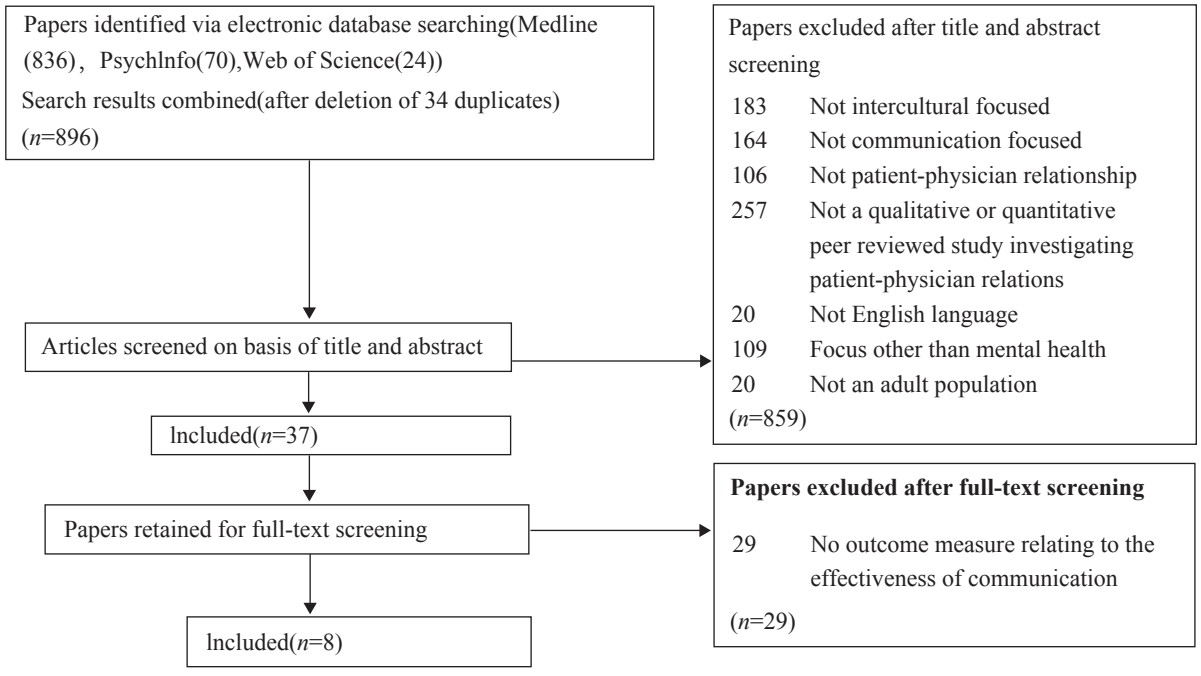

Figure 1
A Search Strategy and Review Flow Chart, Following the Inclusion and Exclusion Processes That Were Conducted for the Systematic Review on Potentially Relevant Studies

1.3 Quality Analysis

The quality of the eight final studies was assessed using quality assessment scales to determine eligibility for inclusion. The Critical Appraisal Skills Programme quality assessment scale (CASP; 2006) was used to assess qualitative papers. This measure was designed by the National Health Service in the United Kingdom, in order to accurately appraise qualitative research within a health setting. This scale assessed four main areas of bias: rigour, key research methods, credibility and relevance, yielding a score from 0 to 10. Higher scores reflect a greater degree of quality, with scores of 7 out of 10 and above indicating high quality worthy of inclusion. The EBL Critical Appraisal Checklist (2006) was used to assess quantitative literature. This scale was developed for use in a variety of settings, including medical and health care, to analyse the quality and validity of quantitative research (Glynn, 2006). This scale assessed four main areas of bias: population, data collection, study design and results, yielding a score from 0%-100%. A greater score indicates higher study quality, with studies included if they were rated ≥75%. All eight papers passed the quality review.

1.4 Data Extraction

Data was extracted from each included paper on: (a) study type and analysis used; (b) characteristic of participants (including sample size and population, clinician or patient status); (3) cultural factors (including country, cultural background); (4) category of communication and outcome measures (including all factors thought to aid or be a barrier for effective communication). The results were then organised by the communication domains outlined in Teal and Street's model, in order to clarify the extent to which the current empirical literature supports their theoretical framework. Additionally, literature investigating the impact of language differences within a patient-clinician interaction was considered together under the title of language disparity.

2. RESULTS

2.1 Study Characteristics

Of eight studies included within the review the majority (six) were qualitative and the remaining two were quantitative. The total mean score for the six qualitative studies on the CASP quality assessment scale (2006) was 9.33/10, with scores ranging from 8 to10. The percentages for the two included quantitative studies, rated on the EBL Critical Appraisal Checklist (2006) were 75 and 83.3%. How the overall main findings of the review map on to the categories by Teal and Street's criteria of effective communication, with the addition of language disparity, is displayed in Table 1. Given the broad categories defined by the Teal and Street model all results were able to be classified into these criteria. Table 2 reflects the key features and extracted results for each study.

Table 1
Main findings by Domain of Communication and Author

Author	Domains of communication					
	Non-verbal behaviour	Verbal behaviour	Incorporation of cultural knowledge	Recognition of potential cultural differences	Negotiation and collaboration	Linguistic differences
Arthur et al. (1999).	√	√	√	√	√	
Blignault et al. (2008)			√			√
Cross & Bloomer (2010).	√			√	√	√
Eytan et al. (2002)					√	
Jirojwong & Manderson (2001)		√	√			√
Kirmayer et al. (2003)	√				√	
Rosenberg et al. (2006)	√	√	√	√		√
Sandhu et al. (2013)			√	√	√	√

The studies were conducted within a variety of locations over a 14- year period (1999-2012), with three studies conducted within Australia, two in Canada, two in Europe (one in Switzerland and one across 16 European countries; Austria, Belgium, Denmark, Finland, France, Germany, Greece, Hungary, Italy, Lithuania, The Netherlands, Poland, Portugal, Spain, Sweden and the United Kingdom) and one in Hong Kong. All qualitative studies utilised content or thematic analysis, one quantitative study reported an analysis of mean differences, and one frequency and cross tabulation data. There was an average sample size of 52.5 participants (range 20 to 138) in the qualitative studies, and 29 and 391 in the quantitative studies, with this variation in sample size reflecting the nature of the study designs.

The participant population consisted of clinicians in four of the studies, patients in two of the studies, and a combination of patients and clinicians in two of the studies. Clinicians represented a range of professional backgrounds including general practitioners, nurses, psychologists, psychiatrics, counsellors and social workers. All had previous experience treating ethnically and culturally diverse patients within a mental health setting. All patients were reportedly of ethnic minority status, either migrants or refugees, accessing health care in a foreign country to their country of origin. All qualitative studies reported on previous communication experiences of clinicians whilst treating patients, or of patients when using mental health care services with one exception; a study by Arthur, Chan, Fung, Wong and

Yeung (1999), which reported on the predicted response of clinicians when presented with case vignettes. Of the quantitative studies, one study by Eytan and colleagues (2002) analysed the use of interpreters on communication from a patient perspective during the administration of a screening interview for mental disorders. The second study, by Kirmayer, Groleau, Guzder, Blake and Jarvis (2003) assessed clinician reports of previous patient interactions from a cultural consultation service.

2.2 Non-Verbal Behaviour Skills

Four studies reported that non-verbal behavioural skills aided in effective communication. From the clinician's perspective (*n*=20) an empathic understanding, characterised by expressing encouragement and sharing knowledge and experiences, helped to build rapport, establish trust, provide emotional support, empower the client, and in turn increased the client's awareness (Arthur et al., 1999). Another study reported from the clinician perspective (*n*=29) that empathy was related to effective communication (Kirmayer et al., 2003). Communicating attributes such as respect and acceptance of cultural difference could be achieved by clinicians (*n*=53) through body language, for instance wearing appropriate dress and accepting food offered during a home visit (Cross & Bloomer, 2010). One study reported that gestures aided in effective communication for both clinicians (*n*=12) and patients (*n*=24) (Rosenberg, Richard, Lussier, & Abdool, 2006).

Table 2
Empirical Findings and Data Extraction

Author (date)	Study type (analysis)	Sample size and population	Country	Cultural background	Communication status	Category of communication	Primary outcome
Arthur et al. (1999).	Qualitative (thematic content analysis)	(*n*=20) Clinicians 10 ward nurses 10 community nurses working in psychiatric hospitals	Hong Kong	Clinicians -Nurses from Hong Kong treating Chinese patients Patients - Chinese background being treated in Hong Kong	-Response to case vignettes	Effective -Clinicians	SKILLS USED - Comfort supporting (respect, non-judgemental, reassurance, acceptance, listening) - Empathic understanding (empathy, acknowledgement) - Encourage expression and insight (reflection) - Offer advice, information and education -Family based RATIONALE FOR SKILLS - Builds rapport, trust, emotional support - Helps empowerment and cultural orientation - Furthers understanding and awareness of condition
						Barriers -Clinicians	- Difference in cultural beliefs, personal values and expectations - Education background and knowledge deficits
Blignault et al. (2008)	Qualitative (thematic analysis)	(*n*=34) Clinicians and Patients 9 Chinese individuals 13 community members 1 bilingual counsellor 1 psychiatrist 9 other health professionals	Australia	Clinicians -Practicing within Australia with extensive cross cultural experience Patients -Chinese born, with a mean Australian residency of 11 years.	-Previous patient interactions -Previous use of the health care system	Barriers -Clinicians	-Difficult to assess the nature and severity of the problem without an understanding of cultural norms and values -Failure to seek help due to lack of language proficiency - Limited knowledge about health care system hindering engagement

To be continued

Continued

Author (date)	Study type (analysis)	Sample size and population	Country	Cultural background	Communication status	Category of communication	Primary outcome
Cross & Bloomer (2010).	Qualitative (thematic analysis)	(*n*= 53) Clinicians 53 Mental health clinicians	Australia	Clinicians -Practicing in Australia, treating a culturally and Linguistically Diverse (CALD) population	-Previous patient interactions	Effective -clinicians	- Communicate respect, encourage disclosure and acceptance of cultural difference with body language - Interpreters aid communication (although use discontinued once rapport established) -Avoiding stereotyping -Acknowledge or establish communication with key group members: such as family or elders as fosters respect.
						Barriers -Clinicians	- Semantic language difficulties (e.g. no word for mental health) -Cultural appropriateness of addressing female patients
Eytan et al. (2002)	Quantitative (frequencies and cross-tabulations)	(*n*= 319) Patients 319 Asylum seekers	Switzerland	Patient -Kosovo asylum seekers being assessed for mental and medical health status	-Screening interview for mental disorders	Barrier -Clinicians	-Rating of communication was poorest when no interpreter was used, better when relatives were used and best when trained interpreters were used
Jirojwong & Manderson (2001)	Qualitative (content analysis)	(*n*= 138) Patients 138 Health care users	Australia	Patients -Thai women living in Australia	-Previous use of health care system	Barrier -Patients	- Lack of cultural knowledge (unsure why clinician was asking so many questions; perceived as ineffective) - Language barriers; failure to seek help due to lack of mental health language proficiency; unable to express emotions - Discomfort with cultural style of providing information (directness of prognosis of serious illness)
Kirmayer et al. (2003)	Quantitative (analysis of means)	(*n*= 29) Clinicians	Canada	Clinicians -Practicing in Montreal, treating an ethnically diverse population	-Previous patient interactions using a cultural consultation service	Effective -Clinicians	-31% clinicians who used the cultural consultation service reported improved communication, empathy, understanding and therapeutic alliance.
Rosenberg et al. (2006)	Qualitative (content analysis)	(*n*= 36) Clinicians and Patients 12 Clinicians 24 Patients	Canada	Clinicians -Family physicians, treating patients of ethnic minority origin Patients -Patients accessing health care services within Canada with an ethnic minority background	-Previous patient interactions -Previous use of the health care system	Barrier -Patients	-Lack of language fluency -Fail to understand but don't ask for clarification -Fear that the clinician will not understand them
						-Clinicians	-Limited ability to describe symptoms -Patients use different idiomatic expressions -Stereotyping and using inaccurate knowledge
						Effective -Clinicians	-Short sentences, gestures, repetition and alternate words. Check for comprehension - Knowledge of mental health problems in particular cultures - Knowledge of family relationships (spousal and child rearing)

Continued

Author (date)	Study type (analysis)	Sample size and population	Country	Cultural background	Communication status	Category of communication	Primary outcome
Sandhu et al. (2013)	Qualitative (thematic analysis)	(*n*=34) Clinicians	16 European Countries	Clinicians -Varied mental health professionals delivering care to first generation immigrants throughout the European Union	-Previous patient interactions	Barrier -Clinicians	- Language barriers; difficult to judge symptom severity and ability to adequately diagnose - Difficulty differentiating between beliefs and symptoms and divergent belief systems may conflict with practitioner's understanding. -Difficulty with cultural expectations due to divergent belief systems; difficulty separating culturally normal response from pathology
						Effective -Clinicians	-Engagement with family members can assist understanding of patient's behaviour and experiences within cultural context where there is a language barrier. Family members hold important information. -Need for knowledge and awareness of cultural difference within mental health services, as will potentially impact on diagnosis and treatment

2.3 Verbal Behaviour Skills

Three studies reported on verbal behavioural skills, the way verbal information is delivered and the content of verbal discussions as all impacting on effective communication. Clarification, reflection, repetition and concise, direct language was reported as effective aids to communication for clinicians in two studies (Arthuret al., 1999; Rosenberg et al., 2006). Short sentences, use of repetition and alternate words were shown to be effective in aiding communication for clinicians (Rosenberg et al., 2006) whilst patients (*n*=138) had difficulty communicating symptoms and experienced discomfort if a prognosis was delivered in an overly direct manner (Jirojwong & Manderson, 2001). Moreover, talking too much was interpreted culturally as a sign of poor clinical skills with these Thai patients in Australian mental health settings. The content of verbal exchanges was also reported on (Arthur et al., 1999), with clinicians purporting that offering advice, information and education to patients was shown to increase understanding and awareness of health conditions from the clinician's perspective.

2.4 Incorporation of Cultural Knowledge

Five of the eight studies reported on the use of cultural knowledge as an influential factor regarding effective communication. One study reported that clinicians regarded knowledge deficits, such as lack of awareness of patients' cultural beliefs, personal values, educational background and patient expectations as being a pivotal barrier for effective communication (Arthur et al., 1999). Clinicians' (*n*=11) inability to assess the severity of the problem, or communicate symptoms, without an understanding of cultural norms and values, whilst a patients' (*n*=9) limited knowledge about the health care system was believed by clinicians to hinder engagement (Blignault et al., 2008); highlighting that this was an important factor for not only communication but also treatment. Similarly, clinicians' (*n*=34) difficulty differentiating between beliefs and symptoms due to divergent belief systems impacted on diagnosis and treatment (Sandhu et al., 2013). Consequently, it was predicted that when clinicians possess cultural knowledge, barriers to communication will be minimised. One further study reported that clinicians find knowledge of particular cultural mental health problems aids in effective communication; as does knowledge of family relationships, such as child rearing practices and spousal relationships (Rosenberg et al., 2006). Aspects of the clinical encounter that don't accord with cultural norms, such as rapid speech or the young age of a health professional, can hinder communication through a lack of perceived clinical expertise by patients (Jirojwong & Manderson, 2001).

2.5 Recognition of Cultural Differences

Perceived differences in cultural beliefs, values and attitudes lead to barriers in communication between patients and clinicians (Arthur et al., 1999). Similarly in

a European sample of clinicians working cross-culturally, differences in cultural expectations between clinicians and patients due to divergent beliefs were shown to be a difficulty for clinicians (Sandhu et al., 2013). Communication was disrupted when clinicians stereotyped and used inaccurate knowledge, such as when interpreting expressions of distress (Rosenberg et al., 2006). Whilst avoiding the use of stereotypes, and recognising individual differences was stated, by clinicians, to aid effective communication (Cross & Bloomer, 2010).

2.6 Negotiation and Collaboration

A number of studies reported on the use of cultural services, family members and translators when language differences were present, in order to negotiate the health communication and work in a collaborative manner. One study found that 31% of clinicians who used a cultural consultation service reported improved communication, through increased empathy, understanding, and therapeutic alliance (Kirmayer et al., 2003). Family based interventions may be appropriate and aid communication in certain cultural contexts (Arthur et al., 1999), such as assisting in the clinicians' understanding of patient behaviour and symptoms when language differences exist (Sandhu et al., 2013). One study reported that family should be involved in decision-making, and discussing treatment with elders was beneficial. However, having to communicate through a husband when treating a female patient was not easy for clinicians (Cross & Bloomer, 2010). Two studies reported that the use of interpreters aided in effective communication (Cross & Bloomer, 2010; Eytan et al., 2002). In a quantitative study (Eytan et al., 2002) ratings of communication with patients were poorest when no interpreter was used, better when relatives were used, and best when trained interpreters were used ($p < .001$). However, interpreter service use was often discontinued by clinicians once rapport was established (Cross & Bloomer, 2010).

2.7 Language Disparity

Overall five studies reported on the difficulties language disparity placed on effective communication for both clinicians and patients. Two studies reported that language was a significant barrier for patients being able to communicate symptoms and express emotions, resulting in a failure to seek help and engage in communication with mental health professionals (Blignault et al., 2008; Jirojwong & Manderson, 2001). Three studies reported that patients' language and literacy ability were a major barrier for clinicians when language disparity was present (Cross & Bloomer, 2010; Rosenberg et al., 2006; Sandhu et al., 2013). Clinicians reported difficulties with semantics and an inability to describe symptoms in simple terms when a language barrier existed (Cross & Bloomer, 2010; Rosenberg et al., 2006). Lack of language fluency was a common cause of clinicians' failure to understand the patients' problems, an inadequacy judging symptoms severity and consequently an impaired ability to correctly diagnose (Sandhu et al., 2013). When this difficulty occurred, clinicians often failed to seek clarification or patients failed to speak up, for fear of being further misunderstood (Rosenberg et al., 2006).

3. DISCUSSION

The purpose of this systematic review was to evaluate the published empirical literature on factors that aid or act as a barrier towards effective intercultural communication between patients and clinicians in a mental health setting. Using the theoretical framework outlined by Teel and Street (2009), this review aimed to assess whether the current literature supported the model's basis for effective communication within a mental health context. This review has also sought to further validate Teel and Street's model through the analysis of language disparity as an important factor that may impact communication effectiveness within this setting. To our knowledge, this is the first systematic review to analyse the effectiveness of communication within a mental health and cross-cultural setting. Eight studies were included within the review, which reported on both the clinician and patient perspective, from a variety of mental health professionals, over a total of 20 different countries. Therefore although the studies are limited in number, they represent a global view of mental health professionals working cross-culturally.

The results highlight specific nonverbal and verbal skills, as well as more general behavioural strategies that aid in effective communication in an intercultural context. These skills, such as the use of empathy, are also supported more widely within the broader literature (Kemper, 1992). When clinicians lacked knowledge of the patients' cultural beliefs and values, the results suggest that this posed a significant barrier to effective communication and appropriate treatment. This finding highlights that when this key communication strategy is not in place, communication will be less effective. The review also supported the recognition of cultural differences as important in aiding communication. Higher levels of cultural sensitivity and cultural competence were shown to be correlated with more effective communication, though an unrecognised cultural difference between clinicians and patients leads to barriers in communication; through the use of stereotyping and incorrectly interpreting expressions of distress. It appears therefore that it is important to firstly recognise cultural differences, and secondly to interpret these differences in a meaningful way. However, correct interpretation is hinged on possessing concise communication skills and appropriate knowledge and can be especially difficult when working cross-culturally.

The current review also analysed the impact of language disparity on intercultural interactions between clinicians and patients. The results suggest that the ability to adequately express emotions, symptoms and medical information is greatly diminished when a language barrier exists. Consequently language disparity poses a significant challenge for both patients and clinicians and impacts on the ability to appropriately assess, accurately diagnose and effectively treat. However, the available evidence suggests that when language disparity exists, the use of interpreters can aid the effectiveness of communication. Although these studies are limited, they support widely held views that the use of interpreter and culturally sensitive services within a health care setting are beneficial (Costantino et al., 2009; Garrett et al., 2008). Additionally, the inclusion of family members in assessment may be beneficial in furthering clinicians' understanding of patient symptomology and distress within a cultural context when language barriers exist.

Taken together, the results largely support the theoretical framework of effective communication skills and cultural competency, outlined by Teel and Street (2009), providing support for the model's utility. The skills of non-verbal and verbal behaviour reported within the current review map on to the domains as outlined by Teel and Street, such as the use of empathy, facial expressions and attentive listening, reflecting and summarising. Similarly, the results are commensurate with the importance of cultural knowledge and recognition of cultural difference when gathering patient information, and therefore pivotal in aiding effective health management and treatment. Yet, other than through an 'assessment' and the inclusion of family members, both the current results and theoretical framework are currently limited in providing specific strategies into how this information should be attained, which clinical communication skills can be utilised when acquiring knowledge, or which cultural information is pertinent. The results from the current review do suggest however, that the importance of language disparity as a barrier to effective communication could be added to this model, with interpreter services shown to aid in communication effectiveness when language differences are present. Moreover, whilst Teel and Street already recognise the importance of including family in assessment and health management, the results suggest that when language disparity is present family members may also be influential in aiding communication.

Of clinical relevance, our findings also highlight that communication exchanges that involve third parties can be especially challenging. These challenges included limited access to appropriate interpreter services, and abiding by appropriate cultural expectations during family exchanges. The limited nature of access to appropriate interpreter services is supported within the larger literature, with some authors reporting a growing need for competent health care workers and interpreters in order to ensure health care access and utilisation (Hilfinger Messias, et al., 2009; Horner, 2004). The current literature also highlights significant differences exist between clinicians in the degree to which they work collaboratively with patients, assessed through the degree of translator and extra educational resources that clinicians used. These factors are not addressed in Teal and Street's (2009) model, and highlight the complexity for clinicians in working within an intercultural health setting. Despite these challenges, the results suggest that use of interpreter services will aid the therapeutic relationship, through assisting to build rapport. Even if interpreter service use is not continued past the point of assessment, this use will have a follow on effect; by providing a more accurate assessment, higher acquisition of culturally relevant knowledge, improving the chance of a correct diagnosis and later more effective treatment.

4. LIMITATIONS AND FUTURE IMPLICATIONS

The quantity of current literature investigating the effectiveness of intercultural communication within a mental health setting specifically is limited. In order to assess the magnitude of communication factors the current paper has synthesised the results across different cultural regions in order to assess generally what factors may be effective. The studies included are also diverse in terms of mental health settings, clinicians, and patient populations. Moreover, whilst these studies are all deemed to be of sound quality, they differ in terms of methodology used and approaches taken to assess effective communication. There is a risk therefore, that in synthesizing this research it has been assumed that what has been shown to be effective in one intercultural interaction can be generalised to a similar interaction between different cultural groups, in a different health setting. Different clinical fields may place a different emphasis on the interpretation and importance of cultural factors within a communication. This is shown by research highlighting that even within one setting, clinicians differed in the degree to which they negotiated and collaborated with additional services (Aseltine, Katz, & Holmes, 2011).

However, despite these limitations, the current review provides support for Teal and Street's (2009) model of intercultural communication. Although from different cultural regions, where significant differences in treatment and training may exist, all papers mirrored multiple themes within this model, suggesting some universality in the findings. Future research could therefore build on the model, by further investigating how language discordance within a health care setting specifically impacts on all areas of communication, and ways in which communication can be improved based on these apparent difficulties.

It is also possible that Teel and Street's (2009) model could be extended to incorporate the use of interpreter services as a factor that aids effective communication. Future research could extend the model by incorporating specific skills helpful for clinicians when using interpreter services and navigating the difficulties that language differences pose on patient-physician intercultural communication. Moreover, whilst current literature indicates that possessing cultural knowledge is important, research has not been undertaken that specifically guides clinicians in what knowledge is important, or how this knowledge may be attained, and which communication skills should be/or are currently utilised.

CONCLUSION

Based on the results of this review, further training and research in cultural values and beliefs are a worthwhile focus of future health care implementations, as cultural sensitivity is shown to aid in communication, and lack of awareness poses a significant barrier. However, this may be a difficult process. Understanding the needs of the patient is often complicated by differences in beliefs, values, health behaviour and communication style preferences between cultural groups (Fujimori et al., 2007; Meeuwesen et al., 2009). Moreover, different clinical settings may hold different views on the importance of cross-cultural competence and training, particularly if they themselves originate from different philosophies. These differences mean that culturally competent care in one context may be viewed as culturally incompetent in another (Garrett, Dickson, & Whelan, 2008). Whilst factors affecting the quality of health management and treatment within intercultural health interactions appear difficult to measure and quantify they are nevertheless very worthy of further exploration.

REFERENCES

Arthur, D., Chan, H., Fung, W., Wong, K., & Yeung, K. (1999). Therapeutic communication strategies used by Hong Kong mental health nurses with their Chinese clients. *Journal of Psychiatric & Mental Health Nursing, 6*(1), 29-36. doi:10.1046/j.1365-2850.1999.00180.x

Aseltine, R. H., Jr., Katz, M. C., & Holmes, C. (2011). Providing medical care to diverse populations: Findings from a follow-up survey of Connecticut physicians. *Connecticut Medicine, 75*(6), 337-344.

Bird, S. M., Wiles, J. L., Okalik, L., Kilabuk, J., & Egeland, G. M. (2008). Living with diabetes on Baffin Island: Inuit storytellers share their experiences. *Canadian Journal of Public Health Revue Canadienne de Sante Publique, 99*(1), 17-21.

Blignault, I., Ponzio, V., Rong, Y., & Eisenbruch, M. (2008). A qualitative study of barriers to mental health services utilisation among migrants from mainland China in south-east Sydney. *Int J Soc Psychiatry, 54*(2), 180-190.

Butow, P., Bell, M., Goldstein, D., Sze, M., Aldridge, L., Abdo, S, …Eisenbruch, M. (2011). Grappling with cultural differences; communication between oncologists and immigrant cancer patients with and without interpreters. *Patient Educ Couns, 84*(3), 398-405. doi:10.1016/j.pec.2011.01.035

Calderon, J. L., & Beltran, R. A. (2004). Pitfalls in health communication: Healthcare policy, institution, structure, and process. *Medgenmed [Computer File]: Medscape General Medicine, 6*(1), 9.

Chung, R. C., & Singer, M. K. (1995). Interpretation of symptom presentation and distress. A Southeast Asian refugee example. *Journal of Nervous & Mental Disease, 183*(10), 639-648. doi:10.1097/00005053-199510000-00005

Collins, J. L., Mathura, C. B., & Risher, D. L. (1984). Training psychiatric staff to treat a multicultural patient population. *Hospital & Community Psychiatry, 35*(4), 372-376.

Cooper, L. A., Roter, D. L., Johnson, R. L., Ford, D. E., Steinwachs, D. M., & Powe, N. R. (2003). Patient-centered communication, ratings of care, and concordance of patient and physician race. *Annals of Internal Medicine, 139* (11), 907-915.

Costantino, G., Malgady, R. G., & Primavera, L. H. (2009). Congruence between culturally competent treatment and cultural needs of older Latinos. *Journal of Consulting & Clinical Psychology, 77*(5), 941-949. doi:10.1037/a0016341

Critical Appraisal Skills Programme (CASP). (2006). *Public health resource unit*. Retrieved from http://www.sph.nhs.uk/sph-files/Qualitative Appraisal Tool.pdf

Cross, W. M., & Bloomer, M. J. (2010). Extending boundaries: Clinical communication with culturally and linguistically diverse mental health clients and carers. *Int J Ment Health Nurs, 19*(4), 268-277. doi:10.1111/j.1447-0349.2010.00667.x

EBL Critical Appraisal Checklist. (2006). *Memorial university of Newfoundland*. Retrieved from http://www.nihs.ie/pdf/EBL%20Critical%20Appraisal%20Checklist.pdf

Eytan, A., Bischoff, A., Rrustemi, I., Durieux, S., Loutan, L., & Gilbert, M., et al. (2002). Screening of mental disorders in asylum-seekers from Kosovo. *Australian and New Zealand Journal of Psychiatry, 36*(4), 499-503. doi: 10.1046/j.1440-1614.2002.01044.x.

Fujimori, M., Parker, P. A., Akechi, T., Sakano, Y., Baile, W. F., & Uchitomi, Y. (2007). Japanese cancer patients' communication style preferences when receiving bad news. *Psychooncology, 16*(7), 617-625. doi:10.1002/pon.1102

Garrett, P. W., Dickson, H. G., & Whelan, A. K. (2008). Communication and healthcare complexity in people with little or no English: The communication complexity Score. *Ethn Health, 13*(3), 203-217. doi:10.1080/13557850701837328

Gilmer, T. P., Ojeda, V. D., Barrio, C., Fuentes, D., Garcia, P., Lanouette, N. M., & Lee, K. C. (2009). Adherence to antipsychotics among Latinos and Asians with Schizophrenia and limited English proficiency. *Psychiatr Serv, 60*(2), 175-182.

Glynn, L. (2006). A critical appraisal tool for library and information research. *Library Hi Tech, 24*(3), 387-399. doi:10.1108/07378830610692154

Hilfinger Messias, D. K., McDowell, L., & Estrada, R. D. (2009). Language interpreting as social justice work: Perspectives of formal and informal healthcare interpreters. *ANS Adv Nurs Sci, 32*(2), 128-143. doi:10.1097/ANS.0b013e3181a3af97

Horner, R. D., Salazar, W., Geiger, H. J., Bullock, K., Corbie-Smith, G., Cornog, M., Flores G, & Working Group on Changing Health Care Professionals B. (2004). Changing healthcare professionals' behaviors to eliminate disparities in healthcare: What do we know? How might we proceed? *American Journal of Managed Care, 10*(SP), 12-19.

Hoye, S., & Severinsson, E. (2010). Multicultural family members' experiences with nurses and the intensive care context: A hermeneutic study. *Intensive & Critical Care Nursing, 26*(1), 24-32. doi:10.1016/j.iccn.2009.10.003

Jirojwong, S., & Manderson, L. (2001). Feelings of sadness: Migration and subjective assessment of mental health among Thai women in Brisbane, Australia. *Transcultural Psychiatry, 38*(2), 167-186. doi:10.1177/136346150103800202

Kemper, B. J. (1992). Therapeutic listening: developing the concept. *J Psychosoc Nurs Ment Health Serv, 30*(7), 21-23.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. *Journal of Clinical Psychiatry, 62*(Suppl 13), 22-28; discussion 29-30.

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie, 48*(3), 145-153.

Kirmayer, L. J., Weinfeld, M., Burgos, G., du Fort, G. G., Lasry, J. C., & Young, A. (2007). Use of health care services for psychological distress by immigrants in an urban multicultural milieu. *Canadian Journal of Psychiatry - Revue Canadienne de Psychiatrie, 52*(5), 295-304.

Ayonrinde, O. (2003). Importance of cultural sensitivity in therapeutic transactions—Considerations for healthcare providers. *Disease Management & Health Outcomes, 11*(4), 233-248. doi:00115677-200311040-00004

McCabe, R., & Priebe, S. (2004). Explanatory models of illness in schizophrenia: Comparison of four ethnic groups. *British Journal of Psychiatry, 185*, 25-30. doi:10.1192/bjp.185.1.25

Meeuwesen, L., van den Brink-Muinen, A., & Hofstede, G. (2009). Can dimensions of national culture predict cross-national differences in medical communication? *Patient Educ Couns, 75*(1), 58-66. doi:10.1016/j.pec.2008.09.015

Minas, I. H., Stuart, G. W., & Klimidis, S. (1994). Language, culture and psychiatric services: A survey of Victorian clinical staff. *Australian & New Zealand Journal of Psychiatry, 28*(2), 250-258. doi:10.1080/00048679409075636

Moffic, H. S. (1983). Sociocultural guidelines for clinicians in multicultural settings. *Psychiatr Q, 55*(1), 47-54. doi:10.1080/00048679409075636

Qureshi, A., & Collazos, F. (2011). The intercultural and interracial therapeutic relationship: Challenges and recommendations. *International Review of Psychiatr, 23*(1), 10-19. doi:10.3109/09540261.2010.544643

Qureshi, A., Collazos, F., Ramos, M., & Casas, M. (2008). Cultural competency training in psychiatry. *European Psychiatry: The Journal of the Association of European Psychiatrists*, *23*(Suppl 1), 49-58.

Archie, S., Akhtar-Danesh, N., Norman, R., Malla, A., Roy, P., & Zipursky, R. B. (2010). Ethnic diversity and pathways to care for a first episode of psychosis in Ontario. *Schizophrenia Bulletin, 36*(4), 688-701. doi: 10.1093/schbul/sbn137

Rosenberg, E., Richard, C., Lussier, M-T., & Abdool, S. N. (2006). Intercultural communication competence in family medicine: lessons from the field. *Patient Educ Couns, 61*(2), 236-245. doi:10.1016/j.pec.2005.04.002

Sandhu, S., Bjerre, N. V., Dauvrin, M., Dias, S., Gaddini, A., Greacen, T., & Priebe, S. (2013). Experiences with treating immigrants: A qualitative study in mental health services across 16 European countries. *Soc Psychiatry Psychiatr Epidemiol, 48*(1), 105-116. doi:10.1007/s00127-012-0528-3

Schouten, B. C., & Meeuwesen, L. (2006). Cultural differences in medical communication: A review of the literature. *Patient Educ Couns, 64*(1-3), 21-34. doi:10.1016/j.pec.2005.11.014

Schouten, B. C., Meeuwesen, L., Tromp, F., & Harmsen, H. A. M. (2007). Cultural diversity in patient participation: The influence of patients' characteristics and doctors' communicative behaviour. *Patient Educ Couns, 67*(1-2), 214-223. doi:10.1016/j.pec.2007.03.018

Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: A conceptual framework for teaching and learning. *Medical Education, 43*(3), 229-237. doi:0024-2519/2009/7902-0002$10.00

Teal, C. R., & Street, R. L. (2009). Critical elements of culturally competent communication in the medical encounter: A review and model. *Soc Sci Med, 68*(3), 533-543. doi:10.1016/j.socscimed.2008.10.015

Wiebe, A., & Young, B. (2011). Parent perspectives from a neonatal intensive care unit: A missing piece of the culturally congruent care puzzle. *J Transcult Nurs, 22*(1), 77-82. doi: 10.1177/1043659609360850

Wilczynski, N. L., Haynes, R. B., & Hedges, T. (2006). Annals of General Psychiatry. *Biomed Central, 5*(4), 1-7.

Ziguras, S., Klimidis, S., Lewis, J., & Stuart, G. (2003). Ethnic matching of clients and clinicians and use of mental health services by ethnic minority clients. *Psychiatr Serv, 54*(4), 535-541. doi: 10.1176/appi.ps.54.4.53