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Considerations for Clinicians When Working Cross-Culturally: A Review

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Abstract

Communication between cultural groups, termed intercultural communication, is often difficult or not successful within a mental health setting. It is important to gain a greater understanding of intercultural communication, in order to provide appropriate treatment and care. This literature review first defines what is meant by intercultural communication, before examining the literature on the intercultural dynamics that must be considered when working cross-culturally within a mental health setting. Particular focus is given to the clinical interview, as it is the key mode of communication within therapeutic practice. Intercultural communication is a dynamic process, and to be effective many socio-cultural factors must be considered. Theoretical models of effective intercultural communication within a health context highlight the need for clinicians to possess cultural knowledge and communication skills; however, the utility of such models is yet to be assessed. The research suggests that cultural competency training is one method to promote more effective intercultural communication within a mental health setting, with cultural adaptations to therapies and assessment tools shown to increase communication effectiveness.

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

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INTRODUCTION

Communication between cultural groups, termed intercultural communication, is often difficult or not successful, due to the demands cultural diversity places on communication (Porter & Samovar, 1991). The quality of communication within a medical encounter is diminished where there is a cultural difference between the clinician and patient. Cross-cultural medical encounters tend to be shorter in duration than same culture interactions (Meeuwesen, Harmsen, Bernsen, & Bruijnzeels, 2006) with both doctors and patients responding less affectively (Schouten & Meeuwesen, 2006), and patient participation and satisfaction heavily linked to the clinician's use of affective verbal language (Schouten, Meeuwesen, Tromp, & Harmsen, 2007). This is of importance, as the better quality the clinician-patient communication during assessment and treatment, the better patient outcomes (Patten & Kammer, 2006).

Globally, research shows that ethnic minority status increases the risk of poorer health treatment. Minority cultural groups show poorer health status overall as they are less able to access or receive timely, adequate care (Armstrong & Swartzman, 2001; Cummings & Druss, 2011). Poor community awareness, inadequate linguistic support and a lack of culturally competent practitioners results in difficulty accessing appropriate services for ethnic minorities in the UK (Cowan, 2001). In the United States the growing disparities in care across different ethnic groups highlights a need for cross-cultural medical care, particularly in regards to cross-cultural communication (Betancourt & Cervantes, 2009). Whilst in Australia, physical and mental health outcomes are hindered by communication difficulties between Aboriginal and Torres Strait Islander patients and Non Indigenous clinicians (Cameron, 2010).

Migrant and ethnic minority status also places a heightened risk for the experience of mental illness.

Assimilation and acculturation of migrants into another culture add stressors, which increase the risk of mental health problems (Hwang, Myers, Abe-Kim, & Ting, 2008). Specifically, migrant status has been shown to increase the risk for the development of schizophrenia, depressive symptoms and anxiety disorders (Bäärnhielm & Mösko, 2012). Consequently, cultural awareness, and culturally competent care specifically, is increasingly important within a health care setting (Engebretson, Mahoney, & Carlson, 2008).

Due to the importance of communication in providing adequate health services, the inherent difficulties of cross-cultural communication, and the risk that ethnic minority status places on the provision of adequate treatment and experience of psychological distress, the phenomena of intercultural communication needs to be understood within a health care setting. Additionally, there is a current lack of published reviews that investigates the phenomena of intercultural communication within a mental health setting specifically. This review will first define what is meant by intercultural communication, before examining the literature on the intercultural dynamics to be considered by clinicians within a mental health setting in order to aid communication effectiveness. The review will then highlight research suggesting cultural competency and culturally adapted treatments are a key means for effective intercultural communication within this context.

1. DEFINING INTERCULTURAL COMMUNICATION

1.1 Ethnicity and Culture

In order to define intercultural communication, one must first define cultural standing, or ethnicity. Within the psychological literature, ethnicity has been defined as an individual's orientation to his or her ethnic origins (Young, 2004), linked to a self-awareness of parentage, common origin, beliefs and values. Therefore, an interaction between two persons could be defined as intercultural whenever the communicators perceive themselves to differ in terms of ethnic identification, ethnic customs or ethnic group membership. Culture can be defined as the enduring influence on one's behaviour by the social environment. Culture is learned and practiced through observation and imitation of a community's norms, values and beliefs (Andersen, 1991). A large proportion of our learning of socio-cultural context comes from communicating responses to stimuli within the environment (Young, 1991). Culture is therefore inextricably linked to communication, as it requires the communication and interpretation of predominantly nonverbal messages.

1.2 Communication Models

Two models of communication, by Young (2004), and Gudykunst (2004), define different elements to be considered within an intercultural interaction. Young outlines a Contextual Model of Interethnic Communication. This model proposes that any communication consists of an action or behaviour within three layers of context including; the communicator, the situation and the environment. Behaviour is defined as both external (directly observable) and internal (covert) actions and reactions. The communicator must work to both encode explicit, and decode implicit, behavioural messages, within a situation that may be defined physically, in that it takes place face to face, or via electronic media such as telephone or email. The context of environment within an interaction includes factors such as institutional equity, political standing, and environmental stressors such as economic hardship. Young states that an interaction is inter-ethnic whenever a communicator takes into account, acts or reacts, to a difference in ethnicity or ethnic identity within any layer of context.

Gudykunst (2004) models communication and culture slightly differently, by differentiating between four levels of analysis; individual, interpersonal, intragroup and culture. Communication at the individual level includes factors that influence the way we interpret messages and are motivated to communicate, such as individual self-concept or how one views oneself. Interpersonal includes factors that influence individual response or engagement, such as social networks. Intragroup takes into account actions based on group membership, such as how social identities affect the exchange of information. Communication effectiveness relies on utilising these levels of analysis within any intercultural communication.

Both models, if applied within a health setting, highlight the complex nature of any intercultural interaction. Not only will how clinicians and patients interact with one another be influenced by both the behaviours and actions of each party, but also the contextual background; taking into account socio-cultural and political histories and the setting in which the interaction takes place. Additionally, the interaction will be mediated and interpreted throughout the exchange of many layers of analysis, from interpersonal (how motivated I feel to communicate my symptoms) to intragroup (my role as a patient or practitioner) to cultural (my beliefs regarding health and illness). These communication factors, which impact how the interaction is interpreted and analysed, have been shown to differ across cultures.

2. CULTURAL DIFFERENCES IN COMMUNICATION STYLE AND BEHAVIOUR

2.1 Individualistic and Collectivistic Framework

Health communication behaviours can be defined as existing within either an individualistic or collectivistic

framework (Armstrong & Swartzman, 2001; Yum, 1991). These frameworks are ways of explaining how people interact within a particular culture, and the ways in which relationships are defined. Terms such as these are often used as a way to define communication differences between broad cultural groups, such as a distinction between Western and Eastern practices. For example, Western cultural practices are often defined as individualistic, and collectivist societies are seen throughout Asia, even though not all culturally Western countries are individualist and not all Eastern countries are collectivist. Within this review these terms are utilised as a guide to orient clinicians to cultural differences which may be present, and allow a more comprehensive understanding of working cross-culturally. However, it is important to recognise that significant cultural differences exist both between and within cultural groups. It is therefore beneficial to understand these terms not as discrete categories, but rather as ends to a continuum of cultural expression which are useful to consider when working clinically in a cross-cultural setting.

Within these cultural frameworks, several factors will change the dynamic of the communication, including the communicator's view of the self, view of the illness, treatment goals and the style of communication. Communicators from an individualistic cultural framework are more likely to view themselves as separate from other people with stable, internal traits (Armstrong & Swartzman, 2001), and define a distinct separation between the public and private (Yum, 1991). They may see the cause of the illness as residing within themselves, with treatment goals aimed at the reduction of symptoms. They are also more likely to possess an open and direct communication style, with an emphasis on what is explicitly stated (Armstrong & Swartzman, 2001; Yum, 1991).

However, this is in stark contrast to someone from a collectivist society, who sees themselves as connected to others and defined by their social relationships (Yum, 1991). Someone from a collectivist background is more likely to engage in an indirect communication style, with an overlap between the personal and public relationship. From this viewpoint, an illness can reside 'outside' of oneself, and the return of a function or role may be the valued treatment outcome. For these persons, subtle and indirect modes of communication are likely to be dominant within a treatment dialogue. It is therefore important as a clinician to be aware of one's own frame of reference, as well as that of the patient, as this frame will influence the expectations each holds of the encounter, illness understanding and ultimately communication comprehension.

2.2 Verbal and Non-Verbal Communication

Cultural differences in communication style, and how direct or explicit the communication is, have been defined as high or low context (Qureshi & Collazos, 2011). Communication with a high context style predominantly relies on information in a physical context, with an emphasis on understanding the meaning of a message without direct verbal communication. In this situation much more information is utilised within the interaction outside of explicit verbal messages in order to correctly interpret the situation, for example; relying on body language and facial expression. This differs from a low context communication style, where the majority of the meaning lies within the verbal code (Martin & Nakayama, 2001). Countries differ in the degree of context within their communication style, for instance Japanese and Arab cultures are often defined as high context, whereas German and Scandinavian cultures are defined as low context (Porter & Samovar, 1991).

Nonverbal behaviours, such as body language, somatic or psychological behaviour, are used to communicate illness, and these also differ cross-culturally (Witte, 1991). It may be difficult to identify one's own cultures' nonverbal behaviour, let alone distinguish or identify the nonverbal behaviour of someone from another culture, as nonverbal behaviour is often a subtle, spontaneous and subconscious occurrence (Andersen, 1991). This places increasing pressure on the clinician to correctly interpret and decipher both verbal information and nonverbal behaviour in order to correctly diagnose and treat a patient. A clinician, who is unable to decode the language and narrative used by a patient to communicate their illness, is at risk of providing the wrong diagnosis and treatment (Helman, 2000). However, having a greater cultural understanding of the communication context that a patient uses may allow clinicians to pick up on more communication cues and allow for a better facilitation of the health encounter.

2.3 Behaviours and Attitudes

Due to the nature of being socialised into a particular cultural context, particular behaviours will be labelled as socially appropriate or signs of well adjustment, while others will be deemed signs of ill health. Similarly, some health conditions may present differently. For example, research indicates that the Asian experience of depressive syndromes (Hwang, Myers, Abe-Kim, & Ting, 2008; Ryder, & Chentsova-Dutton, 2012) and mental health generally (Keyes & Ryff, 2003) is much less affective and more likely to be marked by somatic complaints, compared to patients in the USA. Whilst both the primary mental health diagnostic systems, being the DSM-V (previously the DSM-IV-TR) and ICD-10, both incorporate cultural awareness, the validity of western psychiatric categories applied to non-western populations is questionable (Bäärnhielm & Mösko, 2012). Due to these discrepancies in behavioural expression.

Moreover, some syndromes may be culture-bound, in that they form a culturally distinct pattern of clinical characteristics, symptoms and social meanings tied to a particular cultural grouping (Dura-Vila & Hodes,

2012; James & Prilleltensky, 2002). These differences in behavioural expression may increase the chance of miscommunication when interacting between cultural groups, and can assist the forming of prejudiced stereotypes through misunderstanding. This is in large part due to the fact inherent cultural differences exist between the notion of what is meant by health, illness and disease.

2.4 Health Beliefs and Perceptions of Ill Health

Beliefs about health and disease can be seen to differ between Western and non-Western medical frameworks. The biomedical model is the dominant model used in psychiatric clinical practice and research within Western medicine (Armstrong & Swartzman, 2001). Here there is a strong focus on disease, defined as an objective organic malfunction such as a virus or infection, while non-Western medical systems have been shown to focus more on illness, defined as the subjective feelings of ill health (Witte, 1991). For example, both the traditional Chinese and Sanskrit Ayurvedic medical models are based on a theory of internal and external balances of certain elements within the human body, nature and society (Armstrong & Swartzman, 2001).

Different causal attributes for mental distress have been found between different cultural groups, including those with an Asian heritage, white Westerners, or Pakistani born residents of the United Kingdom (Sheik & Furnham, 2000). Cultural attitudes about mental illness will affect a patient's willingness to discuss psychological symptoms and engage in verbal communication. Stigma attached to a mental illness may affect willingness to disclose symptoms and engage in treatment within a psychiatric setting (St Louis & Roberts, 2013; Wagner & Joukhador, 2001). It is important for clinicians to be aware of patient's health beliefs in order to facilitate treatment engagement.

As each medical system is based on logical principles that are embedded within a community's cultural norms and practices (Witte, 1991), if sole focus is placed on one system alone during treatment, the clinician runs the risk of misdiagnosis, inappropriate treatment and poor treatment outcomes through lower treatment compliance (Armstrong & Swartzman, 2001; Rothschild, 1998). Within any community many cultural, demographic or social factors may influence the perception of illness (Helman, 2000). These factors make the interaction and communication between a patient and clinician increasingly complex.

3. CLINICIAN-PATIENT INTERACTIONS

3.1 The Clinical Interview and Therapeutic Relationship

The clinical interview is the most commonly used method for assessment and evaluating individual information within a mental health and counselling framework. Thus it is likely to be one of the first instances of communication between the patient and clinician. Literature suggests that this interview fulfils a need for both the patient and clinician beyond the simple gathering of information, and is paramount for building therapeutic rapport and an ongoing treatment relationship (Pedersen & Pedersen, 1991). Poor communication and a lack of cultural awareness can therefore seriously undermine this therapeutic relationship (Qureshi & Collazos, 2011).

Given the complex nature of intercultural communication it is little wonder that cultural values may lead to difficulties and misunderstanding (Pedersen & Pedersen, 1991). Clinicians will typically expect the patient to respond to a certain degree, whilst expressing a certain level of emotion, and when the patient is seen to deviate from this expectation, either by under or over expressing emotion, this may be interpreted as a sign of underlying psychopathology (Qureshi & Collazos, 2011). However, these communication differences are cultural interpretations, and failing to recognise this may seriously jeopardise the effectiveness of the communication and in turn the therapeutic relationship. In order to aid understanding, the clinician must be able to assess the role behaviour of either party, the expectations that each holds to the nature of the interaction, and the value or meaning in which both interpret the symptoms, behaviour and treatment.

3.2 Degree of Verbal Communication

One important cultural factor is the degree of verbal communication by the clinician or patient, as the expectation of how much and who communicates differs in many traditional societies compared to a Western medical context (Helman, 2000). In Western medical settings often the patient does most of the talking, with the therapist or medical practitioner asking occasional questions to clarify the content. However, this situation is frequently reversed in traditional non-Western societies, where the sign of a good healer is one that does most of the talking and arrives at a diagnosis quickly (Helman, 2000). This difference in the degree of spoken content will impact on a patient's view of the effectiveness and expertise of their clinician, and ultimately the satisfaction with the clinician-patient interaction.

3.3 Socio-Cultural Context

The effectiveness of therapeutic sessions is influenced by the communication of nonverbal expressions. Important aspects to be considered within this interaction are; the use of personal space, appropriateness of direct eye contact, turn taking behaviours, use of gestures and facial expressions, silence, volume of speech and touching (Saldaña, 2001). Each of these factors will differ in their degree of appropriateness within any cultural context. For example, within the United States

direct eye contact, an erect posture and holding the head high are all commonplace but may be interpreted as assertive or even aggressive within different cultures (Saldaña, 2001).

Factors such as modesty, etiquette, and time taken throughout the communication, will also impact on the communication (Witte, 1991), influencing things like who in the family should be consulted or what parts of the body can be discussed. A Western medical context focuses on punctuality and the timely acquisition of information, whilst in Latin American or Middle Eastern cultures it is customary to first spend time on rapport, establish a relationship, enquire after family, before proceeding with a medical consultation (Witte, 1991).

Other socio-cultural factors such as ethnic minority status, importance of family and immigration stressors, will also indirectly impact communication style. These are often high priority for patients (Yamada & Brekke, 2008) as they may be a leading cause for distress. It is therefore beneficial for the clinician to prioritise their solution, rather than focusing on symptomatic complaint. Assessment of these particular factors, and then setting treatment goals to address patient's prioritised outcomes, is likely to aid in communication effectiveness, through rapport building and trust.

3.4 Power and Status

The interaction within a clinical consultation is also defined by power, with power imbalances between a patient and clinician. Within cross-cultural interactions the normally held status of the health practitioner and patient may differ. Status may therefore increase or decrease from the point where one is accustomed, causing confusion within each party's role (Brislin, Cuchner, Cherrie, & Yong, 1986). The person who holds the power influences the communication, by creating and maintaining communication systems that promote a certain way of thinking (Martin & Nakayama, 2001). There is a high risk of this occurring within health care in a Western setting, which is based around a medical model and hierarchical health care system.

3.5 Language

It is important that an assessment or therapeutic session be conducted using the patient's primary language, especially in mental health where there may be a significant emotional component to the presentation (Saldaña, 2001). Inability to communicate effectively due to language disparity can lead to frustration for both the patient and clinician, with language discordance shown to lower patient satisfaction (Patten & Kammer, 2006) and negatively impact psychological wellbeing in migrant populations within Australia (Jirojwong & Manderson, 2001). Increasingly interpreter services are being viewed as pivotal in bilingual communication (Kai, 2005), and in long term psychotherapy, the client's relationship with the interpreter can be as important to the healing process as the content of sessions (Becker & Bowles, 2001). A systematic review of interpreter use within health care revealed that non-literal translations by an interpreter, such as reducing or paraphrasing content, assist in effective communication (Brisset, Leanza, & Laforest, 2013). Translation is therefore more than switching languages, but rather involves negotiating cultures (Martin & Nakayama, 2001).

However, there are inherent difficulties when utilising interpreter services. Problems arise in regards to an interpreter's competence and ability to translate, heightened by lack of familiarity with psychiatric terms or counselling knowledge (Saldaña, 2001). There is also a concern that the limited resources for bilingual workers in a psychology and psychiatric setting will continue to restrict appropriate service delivery (Malgady & Zayas, 2001), lead to an underutilisation of services within the health system (Kale & Syed, 2010) and the needs of patients will continue to be unmet. The question therefore arises, as to how to best ensure effective communication within cross-cultural interactions.

4. FACTORS SUPPORTING INTERCULTURAL COMMUNICATION

A theoretical model of cultural competence and effective intercultural communication within a general health care setting proposed by Teal and Street (2009) posits that clinicians need to have communication skills in the way of discrete behaviours in order to effectively build a therapeutic relationship, gather information, and assess patient problems. Concrete examples of skills include taking time, expressing empathy and respect, utilising active listening, eliciting the patient perspective and attending to socio-cultural factors of the illness. Many of these factors within the model are essential for effective communication generally; however, the more a patient adheres to cultural group norms and cultural representations of an illness, the more skilled the clinician needs to be. Teal and Street emphasise a number of critical communication elements, which they argue must be utilised across skill domains in order for effective communication to take place, including; cultural knowledge, self-awareness and adaptability.

A greater sense of self-awareness is important for understanding how the clinician's own background and customs are influencing treatment (Helman, 2000), or how this interaction will impact on their emotional processes (Brislin, Cuchner, Cherrie, & Yong, 1986). The awareness of transference within a therapeutic relationship allows the clinician to develop a better understanding of their own behaviour, of how this behaviour may affect the patient, and better assess whether an adjustment in behaviour is necessary. Clinicians can implement these skills by being

mindful, showing connection, being attentive towards the patient and not relying on quick assumptions.

4.1 Cultural Competence

Cultural competence means being able to communicate inter-culturally, and the ability to adapt diagnosis and treatment based on cultural information (Qureshi, Collazos, Ramos, & Casas, 2008). There appears to be a consensus within the literature that cultural competence improves both effectiveness and appropriateness of intercultural situations (Arasaratnam & Banerjee, 2011) through the development of knowledge, skills, and attitudes to improve awareness of how various factors, such as culture, immigration status, and race, impact psychosocial development, psychopathology and therapeutic transactions (Qureshi et al., 2008). Recent reviews have found good evidence that training in cross-cultural care and cultural competency improves the skills and knowledge of the health professionals and increases patient satisfaction (Allen, 2010; Beach et al., 2005).

4.2 Patient and Family Involvement

It is increasingly held that patient participation within healthcare will help to empower people seeking care (Teal & Street, 2009; Tran, Haidet, Street, O'Malley, Martin, & Ashton, 2004), by improving patient access to and comfort with speciality mental health services (Beck & Gordon, 2010). Since the late 1990s there have been increases in consumer input in policy development within mental health services (Bevan, 1997; Stankovska, 1971). However, it is important that patient participation and input into what defines competence is carried out in many different cultural contexts. The vast majority of literature simply report on foreign communication patterns compared to North American patients and clinicians (Yum, 1991), with limited research across other geographical locations within a mental health setting.

Family and community involvement alongside culturally competent health care also improves effectiveness of communication and treatment (Fung, Lo, Srivastava, & Andermann, 2012). This relationship is seen globally; from Somali mental health patients living in New Zealand (Guerin, Guerin, Diiriye, & Yates, 2004) to foreign-born psychosis care patients in Sweden (Bäärnhielm & Mösko, 2012). The provision of adequate information regarding what services are available, along with assisting family involvement through education and involvement of supports within the community, will all increase the chance of adequate care delivery and treatment compliance (Patten & Kammer, 2006; Saldaña, 2001).

4.3 Culturally Sensitive Tools and Treatment.

Modifications have been made to outstanding modes of therapy and assessment measures in order to aid communication and treatment effectiveness in a cross-cultural population. For example, culturally adapted cognitive-behavioural treatment was shown to effectively reduce depressive symptoms in a group of Hispanic patients within a primary care setting in the United States (Interian, Allen, Gara, & Escobar, 2008) and for Chinese patients using an internet based program in Australia (Choi, Zou, Dear, Li, Johnston, Andrews, & Hunt, 2012). Additionally, the use of both narrative therapy and nonverbal art therapy approaches, for treating trauma in an Aboriginal Australian population, was shown to be affective (Cameron, 2010).

Numerous assessment tools, such as the CONNECT instrument designed by Haidet and associates (2008) and the Mutual Understanding Scale by Harmsen and colleagues (2005) have also been developed to assess patient's understanding of their illness and create a shared perspective between the patient and clinician, in order to increase effective intercultural communication, patient trust and adherence. Other scales have assisted clinicians to assess their own cultural self-awareness, multicultural openness and cross-cultural communication skills (Mitchell, 2000). These adaptations all help to assist the process of effective intercultural communication within a mental health setting.

CONCLUSIONS AND FUTURE DIRECTIONS

This review has outlined the many factors to be considered by clinicians working cross-culturally. These factors are especially important within a mental health setting, where a therapeutic relationship, appropriate treatment and treatment outcome all rely on effective communication. Intercultural communication is a dynamic and inherently difficult process, with poor communication resulting in poorer treatment outcomes and less effective utilisation of services. Moreover, in order to balance all of these communication strategies within any given interaction a skilled clinician is needed, who is able to maintain communication skills, understand symptoms within a cultural context and empower the patient (Saldaña, 2001). This places increasing pressure on health services to successfully staff and implement finite and culturally appropriate services in order to attain communication effectiveness.

The implementation of recent health policy requirements for culturally diverse populations, within areas such as NSW, Australia, highlights that intercultural communication is a growing area of interest within public health (NSW Ministry of Health, 2012). Whilst the motivation to understand culture and ethnicity has increased within the health system, programs are often developed without considering how they must be tailored to account for the diversity within the population (Sozomenou, 2003). Research shows that patient's opinions on the competency of health care professionals and health treatment differ cross-culturally

(Stepanikova, 2006). Blanket theories and models may miss the cultural nuances that are important within intercultural communication for certain cultural groups. It cannot therefore be assumed that what will be viewed as appropriate or culturally competent by one cultural group is consistent for all cultural groups. The adequate training of mental health professionals in cross-cultural competency and awareness is essential; however, it will continue to be inherently problematic when the training offered views culture solely within a biomedical perspective (Bäärnhielm & Mösko, 2012). There is consequently a growing need to have a more in-depth understanding of the needs of ethnic minority persons accessing health care, and how to aid communication effectiveness through cultural competency.

Current theoretical models, such as that proposed by Teal and Street (2009) highlight the need for skilled clinicians who can manage many aspects of the communication exchange and utilise cultural knowledge; however, the utility of such models is yet to be investigated. Regardless of the notion that possessing some cultural understanding may be helpful, the question arises as to how feasible an expectation it is for all clinicians to have an in-depth cultural understanding of all cultural ethnicities and the variances between and within these cultural groups. Future research could determine whether current models, such as this one, are supported within a mental health setting or within a specific cultural population.

Moreover, there is a lack of current research that indicates specific interrelationships between factors important for effective cross-cultural communication in a health setting, such as possessing cultural knowledge and verbal skills. Future investigations could identify the links between such factors, which may assist clinicians in understanding which skills to prioritise, or how to place importance on certain clinical skills over others. It will also be important to investigate these interrelationships within specific cultural groups in the community.

Additionally, future research is needed to assess the specific cultural needs for patients who either currently or have a need to access health and mental health services within the community, given that culturally sensitive practices have been linked to more effective treatment. This research would aid for a better understanding of what communication factors hinder access to treatment within specific cultural groups and, once that treatment is accessed, what factors foster treatment gains. Further, investigation within the community and health sectors would then identify an appropriate framework of service delivery based on cultural knowledge and awareness.

With a growing multicultural community globally, intercultural communication is both increasingly complicated and important. However, the development of specific cultural tools has shown that some level of cultural competence can be achieved. By providing a shared knowledge base among professionals and a general awareness of cross-cultural issues, a platform is provided for improved care and the facilitation of new knowledge (Bäärnhielm & Mösko, 2012).

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