Original Article

I|J|S|P

International Journal of
Social Psychiatry
1–6

DOI: 10.1177/0020764019888959
journals.sagepub.com/home/isp
SAGE

Scaling the great wall: The impact of communication barriers on quality of psychiatric care in Chinese patients

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Abstract

Background: Racial and ethnic minorities (such as Chinese-speaking (CS)) are known to have less equitable access to mental health services than Caucasians. These disparities have a powerful influence on minority groups that already endure a greater burden from mental health needs.

Aim: The aim was to identify perceived provider barriers to care for CS patients.

Methods: The study involved an 11-item web-based survey to multidisciplinary health professionals in the department of psychiatry at a 75-bed teaching community mental health center.

Results: More than half the respondents agreed that there are disparities in the management of CS versus non-CS patients primarily due to the language barrier (46%). However, older participants and participants who worked fewer hours per week in patient care were less likely to agree (rho = −.27, $p = .05$ and rho = .33, $p = .015$, respectively) that these perceived difficulties prevented them from caring for these patients.

Conclusion: The study revealed that certain modifiable factors like the limited availability of interpreters and culturally appropriate services, rendering psychoeducation and forming therapeutic alliances with CS patients, posed the greatest challenges on inpatient units. In light of these findings, we aim to make recommendations to remediate concerns of limited provider availability by proposing ways to efficiently utilize current resources and advocate for better staffing to improve the overall well-being of this challenging patient subset.

Keywords

Cultural psychiatry, Chinese-speaking patients, language barriers, communication

Introduction

As the notion of patient-centered care evolves, much emphasis is being placed on the cultural appropriateness of management techniques in clinical psychiatry (Kramer et al., 2002). Variability in symptoms of mental illness depends on psychopathology, ethnicity, generational background and acculturation (Immordino-Yang & Yang, 2017). One such group is the immigrant Asian population with mental illnesses, dwelling in community settings in the United States and having limited to no English proficiency.

Chinese-speaking (CS) patients account for a substantial number of the immigrant Asian population residing around and seeking care at community hospitals of large metropolitan cities in the United States (Ahn & Abesamis-Mendoza, 2007). About 77% of the CS population in New York lives in Brooklyn and Queens (Asian American Federation, 2013). As with many immigrant communities that are often subject to limited access to mental health services, one major provider-related concern is around these patients presenting to the emergency room when their mental illness is severe enough to cause functional limitation and/or result in inpatient hospitalizations and bring them and their families' distress. The cause of this potential behavior, although apparently multifactorial,

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could largely stem from the lack of awareness about the illnesses and the stigma associated with them in addition to limited access to services.

The prominent issues during the course of their illness and hospitalization are around their social structure, family and home environment and their inability to participate and derive adequate benefit from the therapeutic milieu on inpatient units due to the language barrier (Asian Pacific Islander Health Forum, 2006; Benish et al., 2011). The issue is compounded by the dearth in the number and availability of bilingual and culturally competent providers, the tendencies of basing treatments on models most suited to the average middle-class White American patient and the lack of conceptualization of mental health issues in Asian populations (Aggarwal, 2017; Alarcón et al., 2009). One study has also reported that Chinese psychiatric patients are relatively passive and seldom speak up and express their needs (Siu et al., 2016). The paternalistic approach adopted by traditional Chinese mental health professionals to design care plans makes this even more challenging for providers of today to try and find middle ground (Liu et al., 2011).

A study reported that, despite having objective indications of psychiatric disorders, only 19% of all Latino and Asian immigrants in the study had used any mental health services (Kim et al., 2010). Another study found that the rate of mental health service use by US-born individuals was almost twice that of immigrant Asian Americans (Le Meyer et al., 2009). This is consistent with the Abe-Kim et al. (2007) study, which also reported that US-born individuals used mental health services at higher rates than immigrants.

In addition, inaccurate historical stereotypes and a lack of understanding of ethnopharmacology, cultural backgrounds, beliefs and practices and other such pitfalls of traditional mental healthcare have been identified in literature, particularly with respect to the Asian population (Hall, 2001). And while on the one hand, it is of essence to comprehend the scientific basis of differences in response to various treatment strategies, it is of equal importance to be cognizant of the culture-specific views of emotional and psychological health, common somatic and physical manifestations of stress and coping mechanisms in various kinds of psychological distress.

This article provides an understanding of the current practices of mental healthcare of CS patients in our community/teaching hospital situated in Brooklyn. It is the first qualitative study that focuses on the perspectives of providers about the difficulties and barriers they experience while managing these patients. Finally, it suggests targeted interventions for improving the quality of care and addressing the disparities that we hypothesize exist between CS and non-CS patients with regard to full utilization of mental health services at our hospital.

Methods

Study design and population

An 11-item web-based survey was administered to multidisciplinary health professionals in the department. They comprised attending and resident psychiatrists, registered nurses, mental health workers, activity therapists, and social workers. A total of 68 staff members were invited to participate, and of them, 53 chose to complete the survey, accounting for a 78% response rate. Almost all the non-respondents were in the age bracket of 20–39 years, had worked in mental health for 0–5 years and spent the same number of hours per week on clinical care as respondents did.

Recruitment methods included emails to the heads of inpatient psychiatric units, nursing and social work staff introducing and explaining the purpose of the project. They were informed that a short survey would be circulated among staff for a 6-week period from August to October 2017. Follow-up contacts were made in-person and via emails to non-respondents. Piloting revealed an average completion time of 10 minutes.

Measurement: instrument content

The survey instrument (provided on request) was divided into two sections: the first, capturing demographic information of respondents and the second, focusing on the attitudes, perceptions and current practices of providers on inpatient units while dealing with CS patients. More specifically, a question was designed to elicit Likert-type scale responses from participants to indicate their level of difficulty with interviewing, following up, obtaining collateral, information and orienting CS patients to the rules and activities on the unit.

It focused on demographic information of the providers and their attitudes/perceptions of the difficulties experienced while interviewing CS patients. It also asked them to identify and rank the major challenges that caused disparities in the management of CS and non-CS patients. Questions related to logistics of daily workflow that could possibly be affected by the language barrier were also asked.

Statistical analysis was conducted using the IBM SAS 9.4 software package.

Results

A complete-case analysis was conducted with responses from $N = 53$ health-care providers from multiple disciplines. Table 1 shows descriptive statistics of demographic information of the study population. The majority of participants were female (64.2%) with the largest represented age group being 50–59 years old (22.6%). Among the study sample, approximately 38% of participants were attending or resident physicians, 22% were registered

Table 1. Demographic characteristics of survey respondents.

Demographic characteristics	*N* (%)
Gender	
Male	19 (35.9)
Female	34 (64.2)
Age (years)	
20–29	14 (26.4)
30–39	14 (26.4)
40–49	9 (17)
50–59	12 (22.6)
60–69	4 (7.6)
Professional title	
Attending physician	6 (11.3)
Resident physician	14 (26.4)
Registered nurse	12 (22.4)
Social worker	6 (11.3)
Mental health worker	11 (20.8)
Activity therapist	4 (7.6)
Years worked in mental health	
0–5	28 (52.8)
6–10	10 (18.9)
11–15	4 (7.6)
16–20	2 (3.8)
21–25	4 (7.6)
>25	5 (9.4)
Hours per week spent on patient care	
1–10	5 (9.4)
11–20	1 (1.9)
21–30	6 (11.3)
31–40	23 (43.4)
>40	18 (34)
Second language	
Spanish	12 (22.6)
Russian	5 (9.4)
French	4 (7.6)
Arabic	3 (5.7)
Other	17 (32.1)

nurses and the remaining 40% were social workers, mental health workers or activity therapists. Most participants (52.8%) had 0–5 years of professional mental health experience, with 77% of participants spending at least 31 hours per week on patient care. Among the reported second languages spoken by study participants, Spanish was the most prevalent (22.6%).

Participants were asked a series of 7-point Likert-type scale questions pertaining to their thoughts on challenges in managing Chinese patients. Table 2 shows Spearman rank correlation coefficient estimates and estimated *p* values for the Likert-type questions versus select participant demographics.

Older participants and participants who worked fewer hours per week were less likely to agree with the statement 'Perceived difficulties in managing CS patients makes me avoid taking on their care' (rho = −.27, $p = .05$ and rho = .33, $p = .015$, respectively). Older participants were also less likely to agree with the statement 'There are obvious disparities in the management of CS and non-CS patients on the inpatient psychiatric units' (rho = −.27, $p = .05$). When asked to rank the greatest challenges in the management of CS patients, 45.5% (Graph 1) indicated language barrier as the most prevalent response.

Participants were also asked to rank a set of options for what they felt caused the largest disparities in the management of CS patients. The first ranked option with the largest percentage was 'Making accurate assessments and providing diagnoses' (32.1%). When asked if they would call an interpreter when any CS patient on the unit attempts to approach them, the majority of participants (51%) responded with 'Probably yes' or 'Definitely yes'. However, a sizable percentage of participants also provided 'Neutral' or 'No' as a response, explaining that an interpreter would not be available immediately or that CS staff was available and a dedicated interpreter was not needed (69%).

Discussion

To our knowledge, this study is the first of its kind to focus on the attitudes and perceptions of providers while managing CS patients in the United States and it has brought to light some important and interesting results. While it is noteworthy that the majority of providers perceived accurately assessing and diagnosing CS patients as the most significant factor causing disparities in management, they also acknowledged rendering psychoeducation as the next big challenge. By extension, it would naturally be difficult to form a therapeutic alliance with these patients in such practice settings.

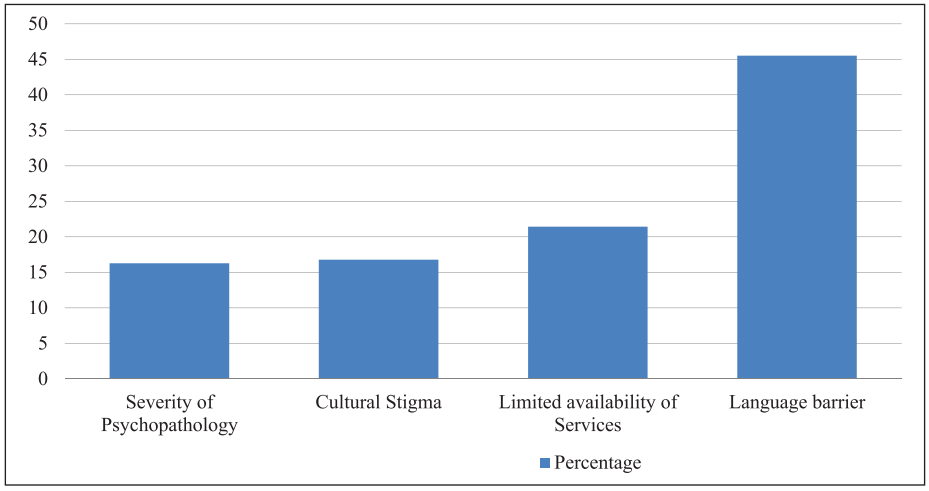
Interestingly, most providers also expressed ambivalence over calling an interpreter when a CS patient approached them on the unit because of being able to rely on other unit staff. While patient–provider familiarity is an obvious benefit in these situations, it is much preferable to utilize interpreters so that information is conveyed to patients in simple terms that are easily understandable to them. Also, the practice of using in-house staff has the potential to create disruptions in daily workflow and lead to inconsistency in availabilities of staff to translate during patient interviews. In addition, although staff might also be native speakers themselves, there is always the possibility that they might insert medical jargon in their conversations with patients, as opposed to practices of trained interpreters.

A third of the participants acknowledged that follow-up interviews with CS patients took longer than those for other patients and knowledge or experience with this could subconsciously deter or make providers less confident

Table 2. Spearman rank correlation results by provider demographics for Likert–type scale questions about management of CS patients.

Pertinent Survey Questions identifying barriers to care	Gender*	Age*	Years working in mental health*	Hours per week spent on patient care*
It is challenging to interview CS patients	.01 (.923)	.09 (.509)	.24 (.080)	.09 (.520)
Perceived difficulties in managing CS patients makes me avoid taking on their care	−.08 (.558)	**−.27 (.050)**	−.26 (.062)	**.33 (.015)**
There are obvious disparities in the management of CS and non-CS patients on the inpatient psychiatric units	.16 (.266)	**−.27 (.050)**	−.08 (.587)	.25 (.075)
Obtaining timely in-person interpreter services is difficult on inpatient units	−.07 (.602)	.14 (.323)	.04 (.783)	.05 (.741)
It is challenging to obtain collateral information for CS patients	−.12 (.397)	−.17 (.229)	−.18 (.196)	.15 (.294)
Orienting CS patients to the unit and group rules requires more effort than for the average psychiatric patient	.11 (.452)	−.1 (.469)	.2 (.146)	.16 (.248)
Follow-up interviews with CS patients take more time than for the average patient	−.17 (.224)	.06 (.659)	.1 (.473)	.13 (.372)

CS: Chinese-speaking.
*Numbers outside parenthesis indicate Spearman rank correlation and those within indicate *p* values. Significant *p* values are in bold.



Graph 1. Participant percentage ranking to 'Challenges perceived in the management of Chinese-speaking patients'.

about taking on their care. Participants acknowledged that the language barrier and lack of availability of culturally appropriate services were the primary limitations on inpatient units. This information has provided grounds to look into an area of need and an opportunity to improve quality of the services rendered.

A potential solution to the language barrier in absence of a live interpreter is that of utilizing telephones or video interpreters. However, it is important to remain cognizant of the flaws of such services: the interpreter's ability to convey empathy or emotion maybe limited, and this medium could also create room for addition, deletion or substitution of information (Lor & Chewning, 2016). Adequate training of the telephone interpreter in these aspects or use of asynchronous therapeutic instruments may be useful to help resolve this problem (Chan et al., 2018).

The relatively small study sample size limited to the inpatient psychiatry staff of one community hospital in Brooklyn is a major limitation of this study, but it brought to the fore the challenges faced by providers in these settings. It highlighted the importance of delivering culturally appropriate care to these populations. A study by Yeung in 2010 examined the effectiveness of a Culturally Sensitive Collaborative Treatment model which reportedly improved recognition and treatment of depression in Chinese patients (Yeung et al., 2010). Before implementation of this model, only 6.5% of these patients were actually diagnosed and treated. Although this model was deployed in primary care settings, some basic tenets could be incorporated into

inpatient psychiatric practice as well. It explained the use of a culturally sensitive psychiatric assessment wherein participants completed an informed consent form before they received a psychiatric assessment from one of the bilingual research psychiatrists. The cultural component used Kleinman's questions to explore patients' illness beliefs and armed with this knowledge, the psychiatrist introduced information on depression in ways that were compatible with patients' beliefs, in addition to using a stigma scale to potentially remove confounders. Finally, a more recently developed resource recommended by the American Psychiatric Association – the Cultural Formulation Interview – provides specific guidelines about the following four core principles for interviewers to keep in mind while obtaining information from these patient groups:

Cultural definition of the problem;

Cultural factors affecting self-coping and past help-seeking;

Cultural factors affecting current help-seeking;

Cultural perceptions of cause, context and support.

Conclusion

While it has been recognized that barriers to receiving appropriate mental healthcare are multifaceted and comprise the lack of health insurance and trouble with copayments in the United States, at an international level, they encompass issues of prejudice against use of psychotropic medications, and application of a culturally appropriate model has the potential to make treatment outcomes for this patient subset comparable or even better than the mainstream patient population in community mental health centers. Given the shortage of staff psychiatrists and the ever-increasing projected need, efficient utilization of technology, personnel, volunteer services and translated material are creative avenues to be explored for allocation of available resources and expansion of access to these patients in a cost-effective manner.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

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