Handout 4-1: Communication Styles

The table below outlines different aspects of communication style and how they tend to vary across cultures. Being aware of how communication styles tend to vary across cultures can help you avoid misunderstandings, but it is also important that you understand your client's unique cultural identity and individual preferences in order to communicate with them most effectively.

COMMUNICATION STYLE	CULTURAL DIFFERENCES	EXAMPLES
Tone, volume, and speed of speech	Culture can influence how loudly it is appropriate to talk, the tone and level of expressiveness in the voice, and the speed of speech. Loud, fast, and expressive speech is common in some cultures but could be considered rude or aggressive in others.	Loud and expressive speech is often more common in African American, Caribbean, Latino, and Arab cultures. Some American Indian cultures, Alaskan native, and Latin American indigenous cultures favor softer tones of voice and less expressive speech, as do some East Asian cultures.
Eye contact	Culture can influence whether it is considered polite or rude to make eye contact when addressing someone, and whether eye contact is necessary to indicate that one is listening.	Direct eye contact is highly valued, both when speaking and listening, by many White Americans. Direct eye contact is considered rude in some Asian cultures.
Use of pauses and silence	Culture can influence whether pauses and silence are comfortable or uncomfortable.	Pauses and silence are uncomfortable for many people who identify with dominant U.S. cultural norms. Some American Indian cultures value silences and pauses as they provide time to process information and gather thoughts.

COMMUNICATION STYLE	CULTURAL DIFFERENCES	EXAMPLES
Facial expressiveness	Culture can influence whether low facial expressiveness is considered normal or interpreted as a lack of understanding, a lack of interest, or even resistance.	Many of the cultures that exhibit high verbal expressiveness also exhibit high facial expressiveness (for example, many cultures from Latin America and the Caribbean). Maintaining a neutral facial expression is more common among some American Indian and Asian cultures.
Emotional expressiveness	Culture can influence how open people are in talking about their feelings. It's important to note that people from cultures that tend to be more emotionally expressive may still think that it is inappropriate to discuss emotions (particularly negative emotions) with people who are not close friends or family.	People from Western European cultures and White Americans are often relatively comfortable expressing that they "feel sad." In some other cultures, people may feel more comfortable showing different emotions, such as anger. In some cultures (for example, some East Asian cultures), expressing any strong emotions could be considered inappropriate. Gender, and how it intersects with cultural identity, can also play a big role in what emotions, if any, people are comfortable expressing.
Self-disclosure	Culture can influence whether talking to others about difficult personal situations is accepted or considered inappropriate. Individuals from cultures where self- disclosure is generally viewed negatively may disclose little about themselves and feel uncomfortable when asked to open up about personal problems.	Self-disclosure may be particularly low for people from highly collectivistic cultures (such as many East Asian cultures), especially if they believe it can bring shame on the family to admit to having a mental illness or substance use disorder. However, it's important to note that level of trust with the provider also influences the degree of a client's disclosure, meaning self-disclosure can be low for someone of any cultural group if there is not sufficient trust and rapport.

COMMUNICATION STYLE	CULTURAL DIFFERENCES	EXAMPLES
Formality	Culture can influence whether personal warmth or respect and formality are more valued.	Many Latinx, African American, and White American individuals prefer a personal and warm style. Clients from these cultures may expect to make small talk and ask questions to get to know a provider. Other cultural groups (for example, some East Asian cultures) may expect a relationship with a provider to be formal, particularly at the beginning.
Directness	Culture can influence whether verbal directness is valued or considered rude.	The dominant cultural norm in the U.S. is to be relatively direct compared to many other cultures. In many cultures (for example, many Asian cultures and Latin American cultures), certain things, particularly those that are negative or embarrassing, should not be said directly but treated with subtlety.
Context	Culture can influence whether communication is high or low context. In low context cultures, words convey most of the meaning. In high context cultures, meaning is conveyed by more subtle verbal and non-verbal cues.	The dominant culture in the U.S. is mostly low context (i.e., words carry most of the meaning), whereas many other cultural groups are higher context. With clients from higher context cultures, it's important to pay attention to non-verbal and situational cues, not just the actual words said. Some messages may be "coded" and not intended to be taken at face value.

COMMUNICATION STYLE	CULTURAL DIFFERENCES	EXAMPLES
Orientation to self or others	Some cultures are much more oriented to the self, while others are more oriented to others. This shows in communication styles through the use of mostly "I" statements versus use of primarily third person and plural pronouns.	The dominant cultural norm in the U.S. is individualistic (self-oriented). Many other cultural groups are more collectivistic (i.e., other-oriented). Members of these groups may speak in third person and use plural pronouns rather than "I" statements. Clients who are more other-oriented may prefer to involve their families and communities in therapy. However, this is not always the case, as stigma and shame can also be particular issues for clients from collectivistic cultures.

Sources:

Galanti, G. (2008). *Caring for patients from different cultures* (4th ed.). Philadelphia, PA: University of Pennsylvania Press.

Purnell, L. D. (2009). *Guide to culturally competent health care* (2nd ed.). Philadelphia, PA: E.A. Davis Company.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment. (2014). *Tip 59: Improving cultural competence. A treatment improvement protocol* (HHS Publication No. (SMA) 14-4849). Retrieved from https://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf

Handout 4-2: Bias in Assessment

Different assessment methods can introduce different levels of bias to the assessment process – whether biased interpretation by the provider and/or bias built into the instrument itself. The table below shows assessment methods in order from less to more potential for bias.

1 LESS POTENTIAL FOR BIAS	Physiological assessment (use of biological markers)
2	Direct behavioral observations (providers' direct observation of clients' behaviors when completing a given task)
3	Self-monitoring (clients' recording of their own behaviors)
4	Behavioral self-reporting scales (instruments that ask clients to recall and report their own behaviors)
5	Clinical interview (structured interview with a provider)
6	Trait measures (self-report instruments that measure personality traits)
7	Self-report of psychopathology measures (self-report instruments that measure clinical diagnoses; e.g., the PHQ-Q to identify depression)
8	Projective tests with structured stimuli (tests such as TEMAS, or Tell me a Story Test, which offer structured visual stimulus cards to elicit story responses that can be used to assess psychological state)
9 MORE POTENTIAL FOR BIAS	Projective tests with ambiguous stimuli (tests that elicit story-style responses to gather information about psychological state using unstructured stimuli; e.g., an ambiguous visual like a Rorschach inkblot)

Source:
Paniagua, F. A. (2013). *Assessing and treating culturally diverse clients: A practical guide*. Thousand Oaks, CA: Sage Publications.

Handout 4-3: Case Study – Mr. Flores and Dr. Johnson

Background

Mr. Flores is a 45-year-old Salvadorian man who has lived in the United States for two years. Spanish is his primary language, and he has limited English proficiency. Mr. Flores is suffering a great deal of stress as a result of the traumatic experiences that caused him to flee El Salvador and the continued difficulties he and his family face in their new home in Iowa. There is a small but closely knit Latinx community in the mostly white town where Mr. Flores and his family live, with many immigrants like Mr. Flores drawn by the availability of work at a nearby meatpacking plant. However, lately everyone is on edge because of rumors of immigration enforcement raids on factories and plants in the area.

Dr. Johnson is a 32-year-old white man who is a psychiatry resident at a mid-sized hospital in Iowa. Although there are a few small immigrant enclaves near the hospital where he is now completing his residency, he is used to working with predominantly White patients and has limited knowledge of the issues affecting immigrant communities in his town.

Case Study (Part 1)

One day, Mr. Flores experiences a strong sense of dread about going to work. He gets increasingly anxious throughout the day. In the afternoon, his heart starts racing, and he begins to experience chest pains. He tells his coworkers he thinks he's having a heart attack, and they take him to the emergency room. The physician on call in the emergency room assesses him and realizes that Mr. Flores is not having a heart attack. The physician decides the issue must be psychiatric, so he calls Dr. Johnson in to conduct a Mental Status Examination (MSE) as part of a psychiatric assessment.

Dr. Johnson introduces himself and briefly explains that he is going to conduct a psychiatric assessment. Dr. Johnson notices that Mr. Flores speaks hesitantly and mispronounces some words, but Dr. Johnson thinks Mr. Flores understands him well enough. After all, Mr. Flores got through his examination with the emergency room physician without an interpreter. Dr. Johnson does not ask for preferred language or offer to request an interpreter, and Mr. Flores does not ask for one.

Dr. Johnson proceeds with the MSE. In several components of the exam, he identifies what he interprets as abnormalities.

First, Dr. Johnson assesses Mr. Flores's speech and observes that Mr. Flores speaks very slowly and sometimes stops midsentence. He thinks maybe Mr. Flores is just searching for the right words, since English is not his native language. However, he becomes more concerned when he assesses Mr. Flores's responses for coherence of thought and tests his concentration. He notes that Mr. Flores gives very simplistic responses, and his thoughts are sometimes disconnected. For example, his responses sometimes reference other parts of the conversation or seem to come out of nowhere.

Mr. Flores also has trouble performing tasks like counting backwards and naming days of the week in reverse. Mr. Flores doesn't respond accurately to general knowledge questions. For example, Mr. Flores cannot remember the state capitol.

Finally, Dr. Johnson notices Mr. Flores is experiencing significant distress. For example, Mr. Flores is reluctant to answer questions and seems extremely tense, fearful, and distrustful throughout the interview. Mr. Flores seems to think that he is being watched by the police and to fear that the hospital staff is trying to get him deported. Dr. Johnson thinks he may be experiencing persecutory delusions.

Dr. Johnson concludes that Mr. Flores is showing MSE signs of psychosis: paranoia, inability to concentrate, disconnected thoughts, and poor performance on general knowledge questions.

Case Study (Part 2)

I didn't wanted to go to the hospital, but I was scared that I had a heart attack. My heart, it was okay, but then they thought something's wrong with my mind and they continued asking me questions. I didn't wanted to tell them where I am from or where I live. I don't know what would they do with that information. What if I can't pay them? What if they just use that information to tell the police things and then they come after me and kick me out of the country?

I really didn't want them to think that I'm crazy because they would held me in the hospital longer, and I don't know what can happen to me there.

I just wanted to go home. But then they brought this doctor, and he start making some test. I didn't understand very well. He just start asking me questions and watching me and then making some notes. I wanted to answer in Spanish because it was kind of hard for me in English, but I was afraid to ask.

I couldn't understand really the point of some questions. Sometimes I tried to answer, and he didn't understand me. I think he thought I was making no sense. So I got scared, and I was scared that they would think that I was crazy and then they wouldn't let me go home.

He asked me some questions about a capitol that I didn't know the answer. He asked me to count backwards and do days of the week backwards and some other things that were hard for me in English, so I got more nervous. I didn't know why they were doing that. For me it made no sense at all.

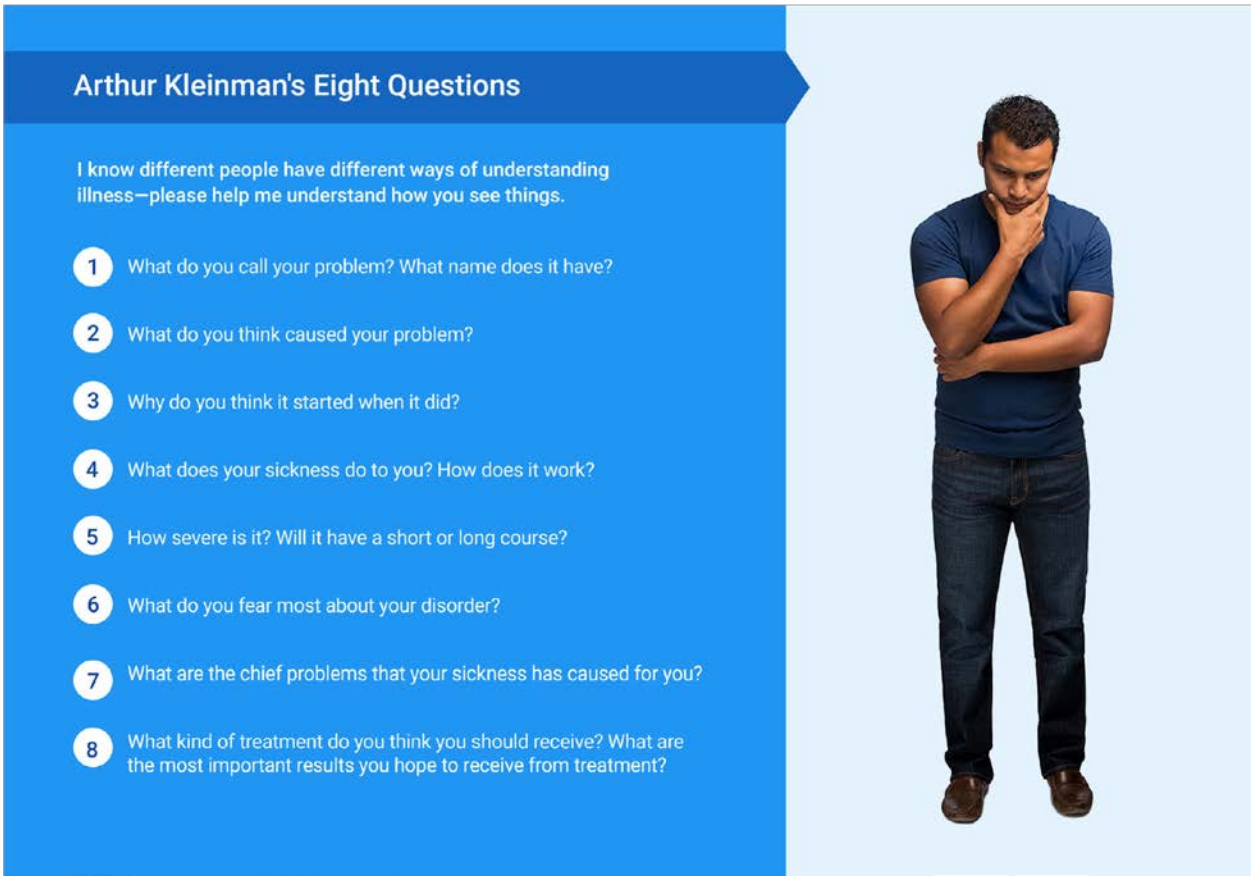
At the end of it, the doctor said that I am showing to be psychotic. He wanted me to come back and talk to him and tried to give me some medicine, but I don't want that. I didn't accept the medicine. After that, they didn't make me to stay at the hospital. I was lucky.

But I'm not feeling very well these days. I mean, it was scary what happened. But I'm not crazy! This thing won't help me at all. I'm never gonna go back to that hospital.

Handout 4-4: Arthur Kleinman's Eight Questions

Understanding your client's explanatory model helps you provide patient-centered care. The explanatory model includes the client's beliefs about their illness, the personal and social meaning they attach to their disorder, expectations about what will happen to them and what the provider will do, and their own therapeutic goals.

The concept of the explanatory model was first proposed by Arthur Kleinman, who developed a set of eight questions a provider can ask a client to learn more about their explanatory model. These questions are below. Note that they are meant to be asked in order.



Source:
Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of internal medicine, 88*(2), 251-258.