American Journal of Qualitative Research
2025, Vol. 9 No. 1, pp. 86-123
https://doi.org/10.29333/ajqr/15881

AMERICAN JOURNAL OF QUALITATIVE RESEARCH
ISSN: 2576-2141

The Centrality of Culture in Primary Care Providers' Approach to Behavioral Health Treatment: A Phenomenological Study

Shane´ J. Gill[1]
Thomas Jefferson University, Philadelphia, PA, USA

Brooke Mauriello[2]
Thomas Jefferson University, Philadelphia, PA, USA

ABSTRACT
Primary care offers an ideal setting to address the effects of systemic racism that contribute to behavioral health disparities for patients who identify as Black, Indigenous, and People of Color (BIPOC). However, addressing barriers to equitable care requires understanding how culture may influence primary care physicians' (PCPs') approach to behavioral health. Using a phenomenological method with semi-structured interviews of six PCPs, we explored culture's role in screening, diagnosing, and treating behavioral health conditions in BIPOC patients. Transcript coding and analysis revealed seven themes surrounding culture that influence PCPs' approach to behavioral health. Findings showed that culture is multi-faceted; race is one of many in a network of factors that PCPs consider when collaborating with patients to make treatment decisions. Achieving equitable health for all persons will require understanding covert and overt factors at each level of the system that, if not accounted for, exacerbate the marginalization of BIPOC patients.

KEYWORDS: Cultural competency, health inequities, mental health, minority health, primary care

In the United States, approximately one in five people (57.8 million) live with a mental illness, and 21.6% receive mental health services (Substance Abuse and Mental Health Services Administration, 2022; Terlizzi & Schiller, 2022). Racial and ethnic biases in medicine and their adverse impact on patient health outcomes are well documented in the literature (Cleveland Manchanda et al., 2021; Eggly et al., 2015; Rogers et al., 2019). Although explicit bias is generally unacceptable among primary care providers (PCPs), implicit biases are common and adversely affect patient outcomes among Black and Latino patients (Blair et al., 2013). Further, racial and ethnic disparities exist in the receipt of mental health services for Black, Indigenous, and People of Color (BIPOC); for example, Hispanic and Latino Americans and Black or African Americans are less likely to receive counseling services (12.9% and 13.5% respectively) and prescription medication to treat mental health disorders (7.7% and 8.6% respectively) (Henry et al., 2020; Marchlin, 2006; Starfield 2012). As knowledge expands surrounding disparities and the role of culture and diversity in primary care settings, it is critical to investigate how culture and diversity influence behavioral health screening, assessment, and treatment for BIPOC patients.

[1] Corresponding author; is a Research Fellow in the Department of Family & Community at Thomas Jefferson University, PA. E-mail; shangil@mail.regent.edu

Literature Review

Structural barriers have been well documented as contributors to inequities in healthcare and disparities in access to treatment for BIPOC patients, resulting in adverse health outcomes (Gee & Ford, 2011). Factors such as stigma, systemic oppression, racism, and discrimination act as barriers to the uptake of mental health services for racially and ethnically marginalized groups (Walker et al., 2015). Although existing models of Integrated Healthcare have been developed to address unique contextual factors that influence behavioral health outcomes for BIPOC patients, these models are not culturally sensitive (Holden et al., 2014). The absence of culturally sensitive models limits our understanding of the implications of diversity between patients and providers and the ability to fill critical gaps in care due to cultural differences (Holden et al., 2014).

The influences of PCP biases on the care of racial and ethnic minority patients are particularly concerning for behavioral healthcare. However, the mechanisms by which implicit biases affect PCPs' assessments, clinical recommendations, and, ultimately, treatment outcomes are complex and largely under-explored (Cleveland Manchanda et al., 2021; Rogers et al., 2019). One way that PCPs' implicit biases contribute to disparities in healthcare quality is through their style of communicating with patients based on their race, ethnicity, or gender. For example, Eggly et al., 2015 found that African American patients, compared to White patients, had significantly shorter visits and received less information about procedures and risks. These differences were attributed to stereotypes and biases about African American patients, differences in communication styles between PCPs and patients, and mistrust of PCPs among African American patients.

Most studies of racial/ethnic minorities and mental health-related treatment outcomes in primary care have solely assessed BIPOC patients' rates of medication prescription and adherence, with existing literature highlighting the role of patients' race/ethnicity in shaping PCPs' perceptions of medication adherence (Baghikar et al., 2019; Bogart et al., 2021; Jones et al., 2018; Mentz et al., 2018). PCPs are often the first to evaluate patients with behavioral health concerns, provide one-third of mental health services, including assessment and evaluation, and prescribe 25% of medication for serious mental illnesses (Jetty et al., 2021). However, there is minimal investigation of PCPs' perspectives on the definition of culture beyond race and ethnicity. Further, the role of culture is underexplored in screening, assessment, and treatment recommendations for BIPOC patients with behavioral health concerns. Literature on factors that impact BIPOC patients' use of referrals for behavioral health counseling in an integrated behavioral health setting is limited, hindering culturally responsive practices to address the behavioral health needs of BIPOC in primary care. Thus, there is a clear need to explore culture in the context of primary care and behavioral health to promote racial and health equity.

The present study examined different components of culture and processes that influence behavioral health practices at the structural, institutional, practice, and provider level in Integrated Primary Care (IPC). The complex nature of these interactions and how they shape PCPs' approach to behavioral health for BIPOC patients in primary care has not been explored. Thus, our aims were to (1) engage with PCPs to understand the processes they use to identify and address patients' behavioral health concerns; (2) explore PCPs' perceptions regarding the factors that impact patients' acceptance and uptake of with non-medication behavioral health treatment; and (3) assess how cultural factors influence PCPs processes of identifying, addressing, and making referrals for non-medication behavioral health treatment for patients who identify as BIPOC. Our findings may inform a patient-centered approach to improve total health outcomes for BIPOC patients.

Theoretical Framework

This study's research questions were designed with the assumption that the term culture describes multiple intersecting identities, each representing an axis of power based on Kimberly Crenshaw's theory of intersectionality (Cho et al., 2013). First coined as a term used in political and legal settings to describe the intersection of race and gender as drivers of bias and power, intersectionality is now a theory and framework. Social structures contribute to increased vulnerability for persons already marginalized on the basis of race, ethnicity, sex, gender, and class (Wilson et al., 2022, all of which are intertwined (Atewologun, 2018). When individuals have a myopic focus on one aspect of person's identity (e.g., race, ethnicity, or gender) this can prevent exploration of how multiple aspects of identity constitute a person's perspective and experiences. This narrow vision produces narratives that aid in structural racism and discrimination (Crenshaw, 1991).

The healthcare industry and medical field have long contended with these complexities, as traditional approaches in treatment were assumed to be universal for all patients (van Mens-Verhulst, 2006). White middle-class men and women have historically been considered the "prototypical patient," with their experiences being generalized to non-White groups (Wilson et al., 2022). Providers' use of an intersectional lens equips them with the ability to identify and understand the interaction of identities and social structures that impact patients' worldviews, responses to illness, and treatment (Wilson et al., 2022). An existential phenomenological approach was used to explore the following overarching research question: How do PCPs' describe the role of culture in screening, assessment, and treatment of BIPOC patients with behavioral health concerns [in IPC settings]?

Methods

Design

The present study used a phenomenological framework and intersectionality theory to explore PCPs' lived experience engaging with BIPOC patients who have behavioral health concerns in IPC settings. In this framework, phenomena are described from the perspective of those who experience them, with an intentional exploration of the meaning persons give to their experiences (Carel, 2011; Collingridge & Gantt, 2019). Piloting was used to explore the relevance of interview questions and alignment with the philosophical and theoretical frameworks and how the PI's identity impacted both the interviewing style and reflexive processes (Sampson, 2004; Wilson et al., 2022). Through piloting, we clarified interview questions, clarified definitions and use of terms, obtained a range of responses from a diverse participant group, and revised questions to promote relevance to the main research question of the study (Chenail, 2011).

The pilot was conducted in two phases. In the first phase, experts were randomly assigned in pairs, each consisting of an interviewer and an interviewee, for the first 20 minutes of didactics. In the second phase, experts were reassigned to new pairs for the remaining 20 minutes. At the conclusion of each interview, the pair would engage in personal and interpersonal reflexivity to explore their expectations, biases, identities, and how these factors impacted the interview process (Olmos-Vega et al., 2022). Experts offered feedback on these processes and suggested revisions to the interview protocol. Recommendations were incorporated to refine the final guide and shared with the experts upon completion.

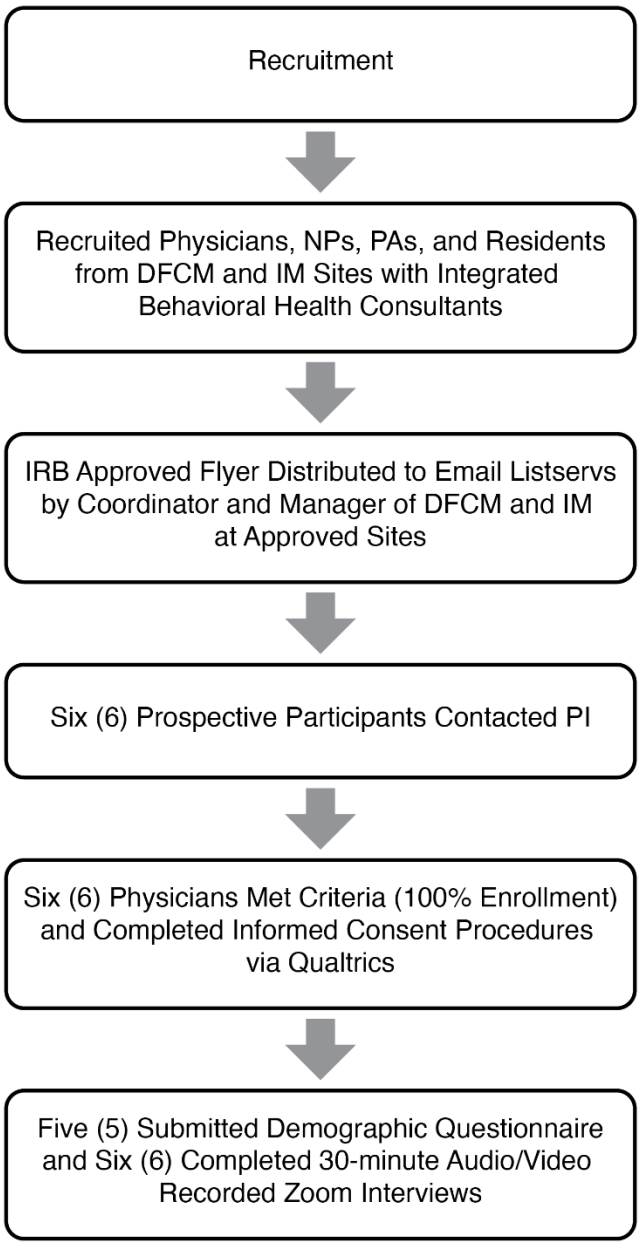
The interview guide was piloted with three postdoctoral fellows, two faculty, and a research coordinator with expertise in primary care and behavioral health. All persons were born female, with one identifying as gender non-conforming. One expert self-identified as Black/African American with the remaining four experts self-identifying as White.

Participants

Table 1 provides information on the characteristics of participants that were recruited across the Jefferson enterprise from the departments of family and community medicine and internal medicine using a flyer distributed by the division leads of both departments, as illustrated in Figure 1. Providers from Einstein and Jefferson Health New Jersey were excluded.

Figure 1
Recruitment and Sample Selection

Figure 1 Recruitment and Sample Selection



Note. This figure illustrates the recruitment process and sample of participants that met inclusion criteria.

The researcher invited participants to report their ethnicity and NIH racial categories to promote autonomy in self-identification and acknowledge diversity in the sample. Participants could opt into a random drawing for a $50 ClinCard as a token of appreciation. Electronic copies of informed consents were sent to participants.

Table 1

Characteristics of Primary Care Physicians (PCPs) in the Department of Family and Community Medicine (DFCM) Center City (CC)Characteristic	Family Medicine (n = 5)[a]
Mean Age (Y)	40.5 (25-63)
Men	63
Women [b]	33
Position (Physician)	5
Department	5
Mean Years in Practice	12.8 (2-38)
Mean Years Providing BH Treatment	14.8 (2-38)
Mean Years in Practice at Thomas Jefferson Univ.	4.3 (0-9)
Sex	
Male	2
Female	3
Gender	
Non-binary	1
Cisgender	4
Race	
White	3
Black or African American	2

Note: The characteristics of the sixth participant are not represented in the table due to their non-response to the survey. [b] Average age for women does not include data from one participant who self-identified as female. The participant declined to answer the question pertaining to age in the survey.

Interviews were transcribed using an experienced professional transcriber through Rev.com. At the end of each interview, transcriptions were compared against the Zoom audio to confirm their accuracy.

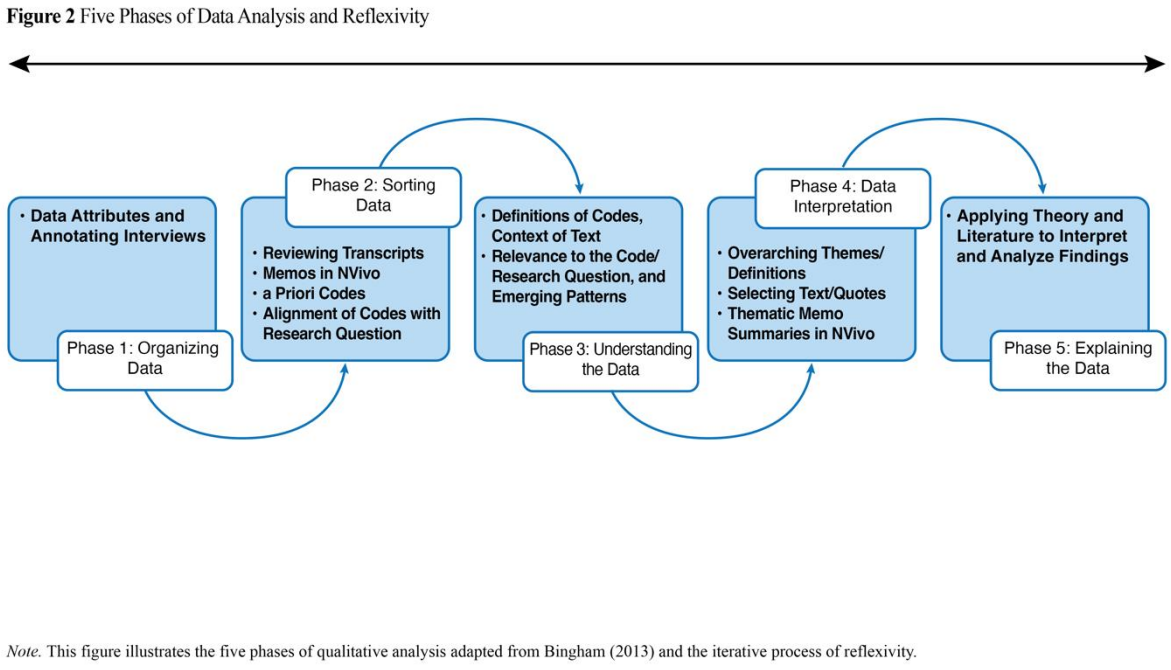
Positionality and Data Analysis

The PI and RC's disclosure of their intersecting identities promotes deliberate self-awareness of their worldviews and the impact on how they assign meaning to participants' experiences, shaping the results and conclusions of the study (Berger, 2015). The PI and RC identified as born female, cisgender, and heterosexual. The PI self-identified as African American/Caribbean (Jamaican ancestry), and the RC self-identified as White/European (Italian). Both parties expressed having lived experience in behavioral health and primary care as patients or providers, with a combined three years of experience in qualitative research and four years using NVivo 14. Both parties documented their initial reaction to each transcript in NVivo by highlighting terms, phrases, and statements that caused a reaction. Prior to and at the conclusion of coding, each party would explore how their identities and history influenced their reaction to the data, assumptions, and meaning (Berger, 2015). Both parties were trained in and used open-ended questions, probing, and asking clarifying questions to promote self-introspection and address possible countertransference in the research process (Borraz et al.,

2021). The researchers used a five-phased approach to qualitative analysis to facilitate the transition from data collection to reporting results using an interactive reflexive process, as shown in Figure 2 (Bingham, 2023).

Figure 2

Five Phases of Data Analysis and Reflexivity



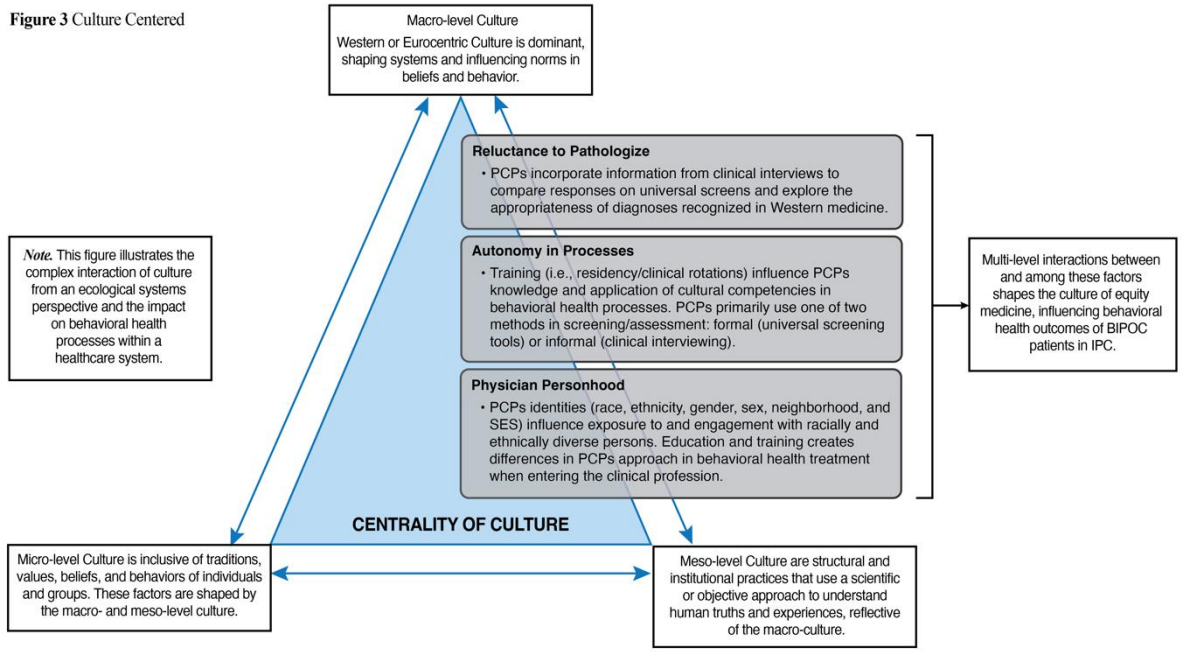
Note. This figure illustrates the five phases of qualitative analysis adapted from Bingham (2013) and the iterative process of reflexivity.

Both researchers conducted an initial review of the literature and of the six transcripts to identify preliminary codes in Appendix A Table A1. The PI and RC met to review the codebook, define terms based on context and nuances of data, and develop processes for modifying the definition of codes or identifying new codes in the data. The pair met weekly to code each transcript, identify and resolve discrepancies, and achieve a consensus on revisions to existing and new codes. Upon completion of coding, the PI and RC were assigned codes to review and develop thematic memos. The PI and RC created analytic and reflexive memos (Kalpokaite & Radivojevic, 2019; Saldaña, 2021). Reflexivity was an iterative process—researchers identified themselves in the inspection cycle to clarify their identities and similarities to and differences between participants (Dodgson, 2019). The themes were developed using iterative comparison to identify language patterns and explore the context and meaning; they named the themes, created a preliminary map to outline the relationships, and defined themes using quotes from the interviews, as shown in Appendix A Table A2.

Results

Phenomenological thematic analysis revealed seven themes that influence the role of culture in the screening and assessment process for BIPOC patients with behavioral health concerns: Definition and centrality of culture, systemic barriers to care, physician personhood, autonomy in processes, reluctance to pathologize, patient-physician alliance, and recommendations for equitable care. Figure 3 illustrates the complexity of culture in healthcare systems from an ecological systems perspective and how these factors may influence behavioral health outcomes for BIPOC populations.

Figure 3
Culture Centered



Theme 1: Definitions and Centrality of Culture

Overall, participants' responses described culture as multifaceted and complex; at the macro-level, culture was described as Western or Eurocentric, directly impacting structural and institutional practices at the meso-level, namely, the adoption of science and objectivity as truth. Western or Eurocentric culture was described by one PCP as a byproduct of colonialism and globalization, allowing for certain groups to be privileged and possess power with the means to influence behavior of other group and individuals. Individuals exist in the context of dynamic groups, including families and communities, each possessing diverse beliefs, customs, and traditions at the micro-level. Interactions within cultures were described as multi-level, with several factors impacting individual and group attitudes, beliefs, and experiences. They acknowledged that there can be multiple cultures that vary by traditions, values, and customs for example, all of which aid in establishing behavioral norms for individuals, families, and larger groups. PCPs' awareness of how culture varies was described as shaping their perspective and interactions with patients. In medical practice, the scientific method requires PCPs to study, name, and enumerate patients' presenting concerns. This method, however, may conflict with patients' cultural values or negate their subjective experiences. A participant described the conflict this creates in being able to capture the essence of their patients' experiences,

> And there's almost like a tension in that sense because if someone's explaining their subjective experience, and the Western biomedical methods I'm using to understand it can't capture it, that doesn't necessarily mean that that person isn't having disease or isn't having that experience or that it isn't a problem or something that then requires healing.

Race and ethnicity alone did not define culture for any of the PCPs. One PCP emphasized the intersectionality of identity when defining culture, reporting that how patients present, their experiences, and their perspectives are shaped by race, ethnicity, gender, and class, for example. Another PCP acknowledged that some experiences may be universal across different cultural groups. However, certain aspects of identity, such as race, ethnicity, and gender, shape attitudes and beliefs about presenting problems; identities (e.g., race, ethnicity,

gender, and socioeconomic status) were described as contributors to how certain experiences "manifest" or how patients "express" their experiences, communicate symptoms, and respond to clinical recommendations across different groups.

PCPs had varying responses about what factors influence racial and ethnic differences in patients' values and their impact on behavior or patient decision-making. For example, one provider reported that for their Latinx patients, the family was central to their identity and culture, with patients' decisions influenced by the impact on their family. For Black or African American patients, the PCP reported that Blackness and how an individual perceives their Blackness are important. Some of these attitudes and beliefs are influenced by socialization, with some patients perceiving their Blackness negatively and exacerbated by loss or separation from their community.

> ...I think oftentimes in the United States, people will use someone's Blackness against them and say it's a negative trait and say that it's almost being able to come to a point where we're undoing a lot of that programming and a lot of that socialization that occurred so that that person cannot hate themselves in that sense. And see that as being a strain and have just almost a shift in the mindset, a strengths-based approach.

Overall, physicians recognized the importance of intersecting identities for perceptions of behavioral health, symptom presentation, and treatment engagement for diverse groups.

Theme 2: Systemic Barriers to Care

Behavioral health treatment for BIPOC patients in primary care settings is influenced by complex interactions among several factors. PCPs reported being unable to provide their desired standard level of care to patients due to structural barriers. Systemic barriers, such as lack of insurance, employment, housing, childcare, and access to telehealth services, impacted patients' access to and feasibility of treatment, both of which were particularly pronounced for their BIPOC patients. For some PCPs, these barriers caused them to feel obligated to assume a role beyond addressing the physical aspects of patients' health, yet they lacked support to create time and space for patients' mental and emotional health. When questioned about ways in which patients' race or ethnicity influence their behavioral health recommendations, PCPs expressed the impact of having to manage time constraints and their duties. One PCP reported often being left to negotiate how to prioritize all aspects of care with limited time, resources, or support.

> ...I think if there were significant resources and we weren't in a resource deficit, I'd probably recommend it [referring to non-medication behavioral health services] much, much more. But I think recognizing that there is a limited amount of resources, I think I'm somewhat judicious in how it's being recommended, given likelihood that it will be received or accepted. And I know that that is probably not a fair and just system either. But I think working in the system that we have—I have to be very intentional about how resources are used.

The institution was described as having a role in patient access to and engagement in services. Despite the use of an IPC model, some PCPs reported having uncertainty about the existing referral system for behavioral health and serving patients with complex needs (e.g., housing, food insecurity, and employment). PCPs described the process in terms of barriers, such as time constraints for patients, urgency of referrals, response time, limited staff, and being unable to leverage personal relationships with behavioral health consultants due to changes in the department. Uncertainty of how urgent referrals for behavioral health services are triaged in the existing healthcare system they worked in due to limited resources.

> I put in an urgent integrated behavioral health referral, but I don't think it's addressed urgently, sadly...If I mark something urgent, I feel like I would hope it gets addressed in a day or two. And I don't think that's the timeline, but I don't think it's anyone's negligence, I think it's the system. I just don't think we have enough people to really do what we need to do.

Feasibility, defined by how reasonably well the recommendations fit with patients' daily responsibilities and how treatment demands impact other areas of patients' lives (e.g., employment and finances), was a prominent barrier to engaging BIPOC patients in treatment. However, compatibility with providers was identified as a key factor for retaining patients in treatment and facilitating consistent follow-up with patients to identify concerns.

> ...You need to listen and tailor the next steps based on what they say. Or sometimes they have bad side effects and that is another reason why...And I think what I try and do is tailor my next steps to why it went poorly. Of course, grounded in evidence-based medicine, but with the person's participation.

Systemic factors impact behavioral health processes in IPC. Treatment access and feasibility were influenced by patients' experiences of systemic barriers, with the health system contributing to PCPs assuming various roles to address the complex needs of their patients. Institutional practices further exacerbated the difficulty in the workflow of referrals of patients and provider practices, both of which impacted patient engagement and retention in behavioral health treatment.

Theme 3: Physician Personhood

PCPs' culture shaped their exposure to BIPOC patients and their awareness of historical events and current practices that impacted patient engagement in behavioral health treatment. In their personal lives, PCPs described different levels of exposure to BIPOC persons based upon their own identities of race/ethnicity, social class, education/training, and geographic region. Two PCPs reported recognizing their privilege and limited knowledge, which they attributed to their racial and ethnic background, social class, and the area where they were raised. Other PCPs explored their lived experiences, reflecting on how these allowed them to relate to their clients. One reported that PCPs should have an awareness of the "context [they] come from" and that their cultural context does not necessarily reflect that of the patient. PCPs did not directly identify their biases; however, they acknowledged the presence and impact of bias. For example, when asked about how patients' race or ethnicity influences their approach to screening and assessment, one provider deflected from identifying personal biases and instead reiterated that historical events have significantly impacted BIPOC patients' trust in the healthcare system and PCPs. He expressed the importance of using this knowledge in tailoring his approach when engaging BIPOC patients who have mistrust in the healthcare system.

> I mean, I try to think about culture when I'm thinking about patients because I think basically sometimes the culture shapes what that person is amenable to or what they're comfortable with... I find a lot of my Black patients are very hesitant because of the legacy of structural racism and the legacy of poor treatment within the healthcare system. And the most common well known one is the Tuskegee syphilis experiment.

Awareness of patients' experiences continued to be salient across PCPs, with many reporting that the use of an open approach that considers these differences is necessary to foster trust. To serve diverse populations that present with complex needs to demonstrate cultural sensitivity and foster trust, a PCP described implementing a strategy of using conscious "type

two thinking to override type one thinking," which involves the "involuntary reactions" that a PCP may have due to bias. In this approach, a PCP attempts to be cognizant of biases, using evidence and logic to counteract thoughts due to bias towards other groups.

Training and education influenced PCPs' exposure to BIPOC patients and attitudes and approaches to behavioral health. Although many of the PCPs currently served a patient panel that was predominantly BIPOC, for some, direct exposure to these populations began during residency. One PCP reported that their medical training was not specific to behavioral health in diverse populations but was grounded in etiology and disease processes, whereas another PCP was able to learn of the role of implicit bias in diagnosing patients of color and alternative methods of questions to identify and understand symptoms in residency.

> I didn't get any training in medical school. But in residency where I'd say if I had to estimate maybe 80, 90% of my population was Black, African American, people of color, and a lot of the cultural...I was told during my training that if you see a diagnosis of bipolar disorder in their chart, ignore it because it's probably not bipolar disorder, it's probably just somebody was angry or upset and they're just like, okay, a bipolar disorder. But then when you ask them questions about mania, depression, things like that, they're like, 'No, of course not.'
>
> And so, you have to, don't ignore it, but just ask more specific questions to see if they actually legitimately have bipolar disorder or not. But that's something also that implicit bias and stuff like that can play a huge role because if it's a Black patient and somebody perceives them as being upset, I'm sure it would happen much more with an African American patient than it would with a white patient. So that's something I learned during my training, which somebody who's not interacting with underserved populations like that probably wouldn't get. That's just one example.

PCPs recognized the duality and interdependence of identities in patient-provider interactions; Identities (e.g., race, ethnicity, and socioeconomic status) influenced providers' exposure to racially and ethnically diverse patients. Medical education and training contributed to overall differences in later exposure, shaping how PCPs understand the behavioral health needs of these patients and how they navigate their biases during patient encounters.

Theme 4: Autonomy in Processes

Behavioral health concerns were identified using formal and informal methods of screening and assessment. Most PCPs reported using universal screening tools (e.g., the Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 Scale (GAD-7), Adverse Childhood Experience Questionnaire (ACE) or one- or two-question screeners to identify physical or mental health symptoms or common disorders. Awareness of cultural differences in patients' labeling and recognition of behavioral health diagnoses, and communication of history within families was influential in PCPs' decisions of whether to use universal screening tools. Although awareness of these was universal, approaches to use this knowledge in determining methods of assessment and diagnosis differed, with other PCPs reporting the use of general approaches to all patient populations. One reported using explicit questions and reflection to evoke patient awareness and insight about their symptoms and management. When questioned about factors that determine universal screening, one PCP stated that she used universal screening when she perceived patients to be minimizing their symptoms or when there were discrepancies between the chief complaint and underlying cause, allowing her to reframe the dialogue with patients.

> I think I use the scale…often when it's a physical symptom, weight loss or sexual dysfunction or something that could be mental health-related or could be something else, and the person seems to minimize the possibility of the effect of mental health. I think that's when I reach for a scale for whatever reason, when it seems like the person to me, maybe the underlying problem here is stress or worry, but the person is really complaining of a different thing.

Informal assessment methods were reported by PCPs as preferred and used most frequently in identifying patients' behavioral health concerns and influencing treatment recommendations. PCPs demonstrated awareness of cultural differences that existed in patients' awareness of and willingness to communicate about their emotions or experiences. For BIPOC patients who may not report individual or family history, one PCP reported that they sometimes used more direct approaches and explicit questions to obtain information vital to identifying their behavioral health concerns.

> ...I don't know that I've heard many patients of color say that they have a family history of depression or alcohol use disorder, substance use disorder. It doesn't really come up. I think it's just that's just how their family members get by. They may have those, I don't know, coping strategies. They may have all those other things, but I don't necessarily think it's labeled as a diagnosis. And so, I ask, I have to sometimes specifically ask past medical and psychiatric history, or I have to be a little bit more explicit because I may not get that level of detail. And I think it's probably not talked about much either.

PCPs formed clinical opinions based on physical assessments and their interpretation of patient statements to express their concerns during patient encounters. Each PCP had a different approach in their method of questioning, types of questions, and strategies for expressing their clinical opinion to patients; some PCPs would ask follow-up questions, prompting patients to quantify changes in their symptoms, whereas others would explore patient symptoms qualitatively. In doing so, some would then be able to introduce diagnostic criteria once they perceived buy-in from the patient and explore the feasibility of treatment recommendations, with several PCPs reporting this being standard practice across all patients.

> I think it would be true of any patient that I have when I discuss these diagnoses, I would kind of just go through what my concerns are, and sort of again, thank them for sharing and saying, 'To come in and talk about feelings that are upsetting to you… that can be difficult, so I give you a ton of credit for coming in and even disclosing what you disclosed to me. And based on what you've disclosed, my concerns are that you're suffering from anxiety or depression or some other mental health issue.' And then I usually just check back and say, 'Based on these criteria, is that sort of where you...' I kind of try to get buy-in from them about, does that feel like I'm going in the right direction? Does it feel like we're on the same page? Yeah, I guess I try not to assume...

PCPs differed in their opinions on the utility of universal screeners with diverse patients. Diagnostic criteria were taken into account when conceptualizing patients presenting problems. PCPs' use of informal methods allowed them to identify the cultural context that shapes patients' symptoms and behaviors and form a clinical impression.

Theme 5: Reluctance to Pathologize

Racial and ethnic differences in BIPOC patients' personal and family history and how they communicated about symptoms influenced PCPs' decision to diagnose patients with a

behavioral health disorder. PCPs reported that BIPOC patients may internalize attitudes and beliefs that influence how they identify symptoms and, consequently, lessen the likelihood of the patient seeking help or being able to identify the need for help. Communication was identified as an aspect of culture that can account for differences in BIPOC patients' expression and management of behavioral health symptoms, with some cultures not labeling symptoms by diagnosis or there being limited discussion within families about history of disease or illness. PCPs described using explicit questions when engaging with BIPOC patients to assess the patient and gather information they may not otherwise be privy to using other methods.

> I think probably communication. I know a lot of people experience symptoms or suffer in silence and may not necessarily talk with others about it. And obviously there's a lot of cultural—I don't want to call it stereotype— but there are definitely individuals who will carry large burdens and may not share that. Or there's often talk about Black women wearing a superhero cape and they do it all and they will do all of these things for everyone else, and they'll care for everyone else and then their health falls to the wayside. And I think—where did that come in from a cultural perspective? I think that that's unfortunately been the way that it's been modeled for generations. We have to take care of ourselves. We have to take care of our families. And so that internalization and reflecting on how that's impacting us individually may not necessarily arise to the top of priorities.

Theme 6: Patient-Physician Alliance

Trust was identified as essential for developing and maintaining a rapport with patients and a necessary condition for engaging patients in behavioral health treatment. PCPs referenced overall mistrust among patients in the healthcare system, emphasizing that patients of color mistrust due to historical events and having lacked quality care. When questioned about processes that would better facilitate conversations about behavioral health with BIPOC patients, PCPs noted the importance of trying to know the patient as a person, fostering trust before discussing physical or mental health,

> You know, negotiating the agenda. But in that connection ritual, if you wish to call it, the things like, 'So, tell me about yourself. And is there anything that you'd want to reveal that would help me help you better?' I think I love the population health question. How's your health?' So, traditionally open an interview with a patient to say, what brings you here today? I greet my patient, I say, hey, how are you doing today? How's your health?'

Anticipating mistrust in the healthcare system influenced PCPs'' approach to engaging patients with behavioral health concerns. Several PCPs reported intentionally scheduling separate appointments or providing patients additional time to discuss factors that impact their mental and emotional well-being, reporting that the traditional appointment and time would not give patients the proper attention they deserve. Patients' history or indirect experiences with services or symptoms influenced communication patterns, and PCPs used examples that patients could relate to and understand. This strategy was often used as leverage in selling the benefits of treatment once buy-in was established.

> And I'll add, sometimes I'll say, because I know you so well, I know that there are multiple things going on right now and in order to allow you to continue to care for your family or care for whatever and continue your job and do the things that you want to do, I think it's important that we also focus on this part of your life. So, I think the goal

> of that treatment to help them go back to their very busy burdens and lives, but to at least help them recognize that it—right now, it's not helping if we're going to just dwell in this space where your mood is not well controlled and you're overwhelmed, but not feeling like you have the tools or resources to cope with it.

Most PCPs agreed that a combination of medication and counseling is most appropriate for patients with behavioral health concerns. However, all PCPs acknowledged the unique challenges often faced by BIPOC patients, with several PCPs referencing time constraints, employment, and familial obligations, coupled with belief systems that impact receptiveness and engagement in these recommendations. PCPs reported using existing knowledge of patients' barriers and goals to explore which option may be most feasible to attempt long-term outcomes. One expanded on this concept, reporting that promoting buy-in sometimes necessitated setting aside her desires and goals for the patient and being intentional about allowing them to define their own goals in treatment.

PCPs differed in their approaches to BIPOC patients' responses to treatment recommendations, with one stating that she must translate the benefits of treatment recommendations to language that is "empathic to their experiences and acknowledges their values" while also accounting for stigma and shame. For another, underserved populations, whom he identified as persons who often score high on the ACE and social determinants of health screening questionnaire, warranted a different approach to address these factors. The physician culture was described as one that should be caring, compassionate, and void of transactions, according to one participant. PCPs were questioned about how patients respond to their recommendations for behavioral health treatment. According to one PCP, the ability to treat patients with dignity requires PCPs to see them as human, and that goes "beyond culture."

> Yeah. Oh, they have a lot that comes up when you ask that question because I'm thinking about specifically my patients that are of color...And I think oftentimes with treatments for specifically behavioral problems, I think at first of all, a baseline level of stigma and misunderstanding around the purpose of some of the treatments that I'll recommend...
>
> I'll recommend, okay, maybe consider going to a therapist, starting some medication or talking to a psychiatrist, those kinds of things. And I get a lot of, 'Do you think I'm crazy? Is that why you want me to do this? I'm not crazy so therefore I won't do this.' And I feel like I have to almost take a step back as a clinician and just even recognize that that reaction is in a context where people are often in, have their experiences invalidated by the medical system, are pitched as being crazy. There's a level of mistrust that's there. That's the context that I'm operating in.

They described the process of promoting client buy-in to treatment as one of empathy and prioritizing the values of the client that are central to their culture:

> So how do I explain to my patient that's sitting in front of me why some of those treatment options would be beneficial to them? How do I translate what it is I'm trying to say and say what they can actually gain from the treatments in a way that fully is empathetic to their experiences, prioritizes whatever their values are in how they want to get better and how they want to heal, usually comes from their culture. So that I can at least be able to translate for them and pitch to them why this treatment may benefit them in that sense.

Theme 7: Recommendations for Equitable Care

Innovations to revolutionize behavioral health and equity for BIPOC patients in integrated health care included recommendations for change at the institutional, provider, and patient levels. The use of a person-centered approach was a salient theme, with most PCPs agreeing that trust must be established, if not re-established, considering historical mistrust in the system and healthcare system. Also, participants identified representation, or the presence of BIPOC PCPs with whom patients can identify as important in strengthening trust and increasing participation of BIPOC patients in behavioral health services. Other recommendations included engaging other systems and ancillary services to target the unique needs of BIPOC patients. PCPs elaborated on the importance of training PCPs to enable them to witness different approaches that are patient-centered and culturally sensitive in order to engage BIPOC patients and identify their goals for treatment. One PCP elaborated on what has been helpful in their training to engage BIPOC patients in conversations about behavioral health treatment.

> Yeah. What has been helpful was being able to engage in discussions, specifically dialogue with a wide range of people where the conversation was about the things that we, especially in medicine, normalize and de-normalize. Those conversations have been very helpful in terms of just understanding then the context in what we're working in and the historical background and how we all got here and why we are doing things in a certain way and not questioning them when they should absolutely 100% be questioned.

Approaches that could be effective for fostering patient engagement and empathy were noted as the trans-theoretical model, motivational interviewing, and a trauma-informed approach. For one PCP, these discussions were seen as also providing an opportunity to learn about diverse perspectives and approaches. They saw patients having a vital role in training PCPs and improving these processes. One PCP recommended that patients provide feedback about the recommendations given by the provider and areas for improvement.

Some PCPs generated new approaches to prioritize patients' care in response to encountering high levels of trauma and scores on social determinants of health screening tools among patients. For example, to reinforce the importance of prioritizing behavioral health at the practice, some PCPs began challenging the existing system at the institutional level by extending appointment times. They also forewarned patients of the rationale for delays. To further support patients who present with complex behavioral health concerns, another provider recommends the integration of "auxiliary services" (e.g., legal, case management, and a food pantry). The inclusion of these services was, from his perspective, necessary to accurately reflect the unmet needs of the diverse patient population that are known contributors to behavioral health disparities in BIPOC patients.

Discussion

First, the current qualitative analysis identified various features of culture that influence PCPs' approach to screening, treatment, and management of patients with behavioral health concerns. PCPs describe the culture at the individual, family, community, and societal levels. Individuals' attitudes, beliefs, and behaviors were influenced by their family of origin and community or environment. Second, individual, structural, and systemic factors were identified that affect patients' access to and engagement in behavioral health treatment in primary care settings. Third, PCPs demonstrated awareness of how insurance, employment, and housing impacted engagement in treatment, with an understanding of how racism serves as a driver of structural inequalities.

The factors identified at the individual and systemic level are known contributors to disparities in healthcare in Black or African Americans compared to Whites. Despite having a high need for outpatient care, Black or African Americans have low utilization of outpatient care, coupled with low insurance coverage, both of which pose limitations to access and feasibility of care (Dickman et al., 2022).

Although PCPs described these systemic barriers as contributors to health disparities, recent literature has also focused on structural racism. Structural racism involves the macrolevels at which processes reinforce inequity, have the most influence, and without force or intent, allow for conditions to be created that perpetuate racial inequity (Powell, 2007). Segregation or isolation of racial or ethnic groups and the influence on health and access to resources have been identified as areas of consideration in understanding the extent of structural racism on healthcare outcomes (Gee & Ford, 2011). The barriers PCPs identified that impact implementation of the Integrated Health Care Model and patient access to behavioral health treatment are known barriers to PCPs' adoption of behavioral health integration practices in various settings (Malâtre-Lansac et al., 2020). Research is needed to explore the presence of these barriers across primary care settings that cater to diverse patient populations and factors that influence adoption of practices.

PCPs did not provide information about their biases. However, they acknowledged the presence and role of bias when interacting with patients, with some having limited exposure to BIPOC patients prior to medical school and residency. Some PCPs expressed the importance of PCPs being knowledgeable of historical factors that contribute to mistrust in the medical system and consequently, PCPs. The use of specific examples geared towards a racial or ethnic group and evading addressing one's personal biases could stem from the general stance that racism and discrimination are undesirable or unacceptable in our current society. Detachment from identifying ones' biases could have been the result of cross-cultural interactions between the interviewer-interviewee, generational differences in communication about values and attitudes and beliefs, responder bias to not be perceived as racist, or "white fragility," a term coined by DiAngelo (2016). In that study's context, the discussion of bias as it pertains to race induced racial stress. Beneficiaries of Whiteness showed many behaviors (e.g., argumentative behavior or debating, silence, avoidant behavior, and exiting the stress-inducing environment, or victimization). In our study, most PCPs' responses to the prompt on bias focused on strategies they would implement to recognize historical events rather than engaging patients in exploring biases that may impact the patient-provider alliance. These results suggest that barriers exist in PCPs' ability to identify and communicate both the presence of biases and the effects of biases in the continuum of care for behavioral health in cross-cultural interactions, potentially contributing to racial and health inequity in screening, diagnosis, and treatment outcomes in primary care settings.

Mistrust in the healthcare system was often described when discussing the experiences of BIPOC patients. As a consequence of racism and discrimination, such mistrust contributes to differences in patient engagement treatment and total health outcomes (Dovidio et al., 2008). PCPs can be at risk of engaging in behaviors aligned with their social identity or role, reinforcing the negative attitudes and stereotypes that perpetuate poorer health outcomes in people of color (Dovidio et al., 2008). PCPs in our study described efforts to recognize their biases, with some referencing knowledge of historical events that contribute to structural and systemic barriers in behavioral health care for BIPOC patients. PCPs agreed that an open approach is warranted to facilitate trust with diverse patients. Medical mistrust may carry a connotation of being culturally specific, with an underlying assumption that mistrust is inherent in people of color (Jaiswal & Halkitis, 2019). That assumption has been described as "likely racist" as it burdens people of color with the responsibility of overcoming mistrust in the medical system, whereas institutions or organizations should be held accountable for environments that foster inequity (Jaiswal & Halkitis, 2019). Caution must be taken as biases

can contribute to discrimination and differences in actions taken to provide medical treatment when comparing BIPOC and White patients (Dovidio et al., 2008).

Although standard universal screening tools were identified and defined as a formal approach to screening, their implementation and utility in diagnosing patients varied across PCPs. PCPs did not specify if the use of universal screening tools was mandatory across the enterprise or at their respective sites. Most PCPs reported using informal methods to obtain information about patients' history, culture, and symptoms, which they used to diagnose patients and determine treatment recommendations. One PCP disputed the utility of universal screening tools, reporting that they were not "particularly useful," instead opting for one- or two-question screening or informal methods. However, screening tools, such as the PHQ-9, have greater accuracy in diagnosing patients with depression (Gilbody et al., 2007). Although direct and indirect evidence supports the use of screening for depression in primary care settings, direct evidence for anxiety and suicide screening was lacking despite evidence supporting psychotherapy and psychopharmacological interventions to treat anxiety (Gilbody et al., 2007). Further research is needed on the sensitivity and specificity of screening tools for identifying other behavioral health conditions and how this knowledge shapes PCPs' attitudes about utility in primary care settings. This issue is particularly important given the increase in PCPs' delivery and direct care for mental health concerns over the past decade (Health Resources and Services Administration, 2023). With increased support of the Integrated Behavioral Health model in addressing behavioral health disparities for BIPOC patients, the impact of inconsistencies in the implementation of universal screening and inequity in the diagnosis and treatment of behavioral health conditions in primary care settings requires further exploration.

Several studies have referenced the recommendations made by the United States Preventive Services Task Force (USPSTF), endorsing screening adults ages 18 and older for depression and providing treatment in primary care settings (Siniscalchi et al., 2020). Increased access to financial capital in clinical settings has prompted a desire for practices to integrate screening tools to increase efficacy in identifying depression, which, for example, has aided PCPs in the diagnosing and treatment process of mental health conditions (Mulvaney-Day et al., 2018).

Also, PCPs reported prioritizing the person and using a person-centered approach, affording them an opportunity to collaborate with patients in determining the appropriate treatment options. Patient-centered care has been identified as a strategy to increase trust in Black or African American patients by fostering respect, responsiveness, and attention to needs, values, and preferences (Cuevas & O'Brien, 2019). Aligning with this, PCPs discussed including patients in the decisions made regarding treatment to promote autonomy and strengthen trust. Shared Decision Making (SDM) is collaborative and assumes that the patient and provider are both experts, improving communication between both parties in the screening and treatment process (Patel et al., 2014). However, the literature on implementation in primary care settings for BIPOC patients with behavioral health conditions is lacking (Patel et al., 2014). To study the effectiveness of SDM in primary care settings that use an Integrated Health Care Model, consideration must be given to factors such as race centrality (the extent to which race is central to one's identity and how one believes others perceive one's racial group, race concordance (similarity in racial identity between the patient and provider), and provider communication style (Adams et al., 2015; Cuevas & O'Brien, 2019). These may impact PCPs' ability to collaborate with patients of the same or similar race. Demographic factors (i.e., PCP education level, experience with BIPOC patients, practice location, race/ethnicity, gender, and SES) should be controlled for and compared to identify the correlation to treatment recommendations made for BIPOC patients with behavioral health concerns. Exploring PCPs' beliefs about mistrust would be essential to identify strategies for shared responsibility across systems, institutions, and PCPs that promote racial and health equity.

PCPs proposed several innovations to transform behavioral health and promote equity for BIPOC patients at the institutional, provider, and patient level. Across the system, participants suggested that PCPs must be trauma-informed and identify social determinants that contribute to adverse health outcomes in BIPOC patients. Some PCPs identified representation and additional training using recommendations made by BIPOC patients as necessities for professional development. Obtaining this information may require time and additional costs to collect feedback from patients, analyze the data, and produce results or recommendations that can be implemented across primary care settings that use an Integrated Health Care Model.

Limitations

There were several limitations to this study. First, saturation was not achieved due to a limited sample size. Additional qualitative interviews would have allowed for greater depth in exploring culture's role in screening, diagnosing, and treating behavioral health concerns in BIPOC patients. Second, despite recruitment efforts, participants in the sample represented one site, which limits perspectives from different practices, policies, and cultures and may be practice-specific. Lack of access to information limits our understanding of other institutional and practice factors that influence PCP approaches in the continuum of behavioral health treatment for BIPOC patients. Although bias was explored qualitatively, a direct assessment of implicit bias did not occur. Cross-cultural dynamics, including racial/ethnic, gender, and generational differences between the researcher and participants, may have impacted participants' responses to direct questions about the role of bias in their approach to BIPOC patients with behavioral health concerns. The perspective of physician assistants, registered nurses, and behavioral health consultants might have revealed other factors that impact screening and assessment and their interpretation of findings for BIPOC patients. The study did not explore how PCPs incorporate and use feedback. Lastly, direct patient interviews may have revealed how they interpret cultural factors influencing the diagnosis and treatment of their behavioral health concerns and recommendations to promote cultural competence in primary care settings.

Implications for Future IPC Research

This study is one of the few that explores the complexity and influence of cultural factors in patient-physician interactions in medical settings and, to our knowledge, the first to define and explore how culture influences behavioral health processes with BIPOC patients who have behavioral health concerns in IPC settings. All participants described culture as multi-layered, with multiple identities (e.g., race, ethnicity, gender, sex, socioeconomic status, etc.) shaping interactions between the patient and physician. The training created opportunities for exposure to diverse patients and awareness of stereotypes that impact provider objectivity in behavioral health assessment. Providers' knowledge of systems and structures that both provide a conceptualizing framework in understanding presenting problems and, often intentionally, reinforce equity was prominent. However, a lack of awareness of personal biases contributes to misdiagnoses and inequity in treatment, with assumptions and experiences based on race being the primary driver (Saha & Beach, 2020; Saldana et al., 2021).

Future research would explore primary care providers' implicit and explicit biases of racially and ethnically diverse patients and how these biases influence mental health diagnoses and treatment recommendations. A pilot study that uses simulation training with racial and ethnically diverse patients presenting with prototypical symptoms that represent mental health diagnoses PCPs frequently encounter can improve medical competence by increasing acquisition of knowledge, potentially reducing diagnostic errors and treatment disparities (Piot, Attoe, Billon et al., 2021; Piot, Dechartes, Attoe et al., 2020). Furthermore, simulation training

that incorporates counter stereotypes (e.g., a Black/African American heterosexual male that is married with a graduate level education or a White single female with less than a high school education), can aid in exploring providers' expectations and experiences of the actor/patient in-vivo and information they use to inform their treatment decisions (Vora et al., 2021). An explanatory design would allow the research to test a verifiable hypothesis on the suspected impact of bias on diagnosis and treatment (e.g., pharmacological or behavioral health counseling) and offer opportunities for clarification from providers' perspectives (Smajic et al., 2022). Knowledge of mechanisms by which bias, directly and indirectly, influences PCPs' decision-making is critical for improving medical curricula on cultural competencies and redefining best standards in the delivery of behavioral healthcare services for racially and ethnically diverse patients.

Conclusion

Our results suggest that culture is multifaceted, with cross-cultural factors between the patient and PCP influencing the screening, diagnoses, and treatment from BIPOC patients. Race and ethnicity are important to consider, particularly when PCPs and patients see each other as differing racially. Although patients may experience similar situations or be exposed to similar conditions, the impact on behavioral health and symptom presentation may differ for BIPOC patients. BIPOC patients' attitudes and beliefs about behavioral health shape cultural norms that influence their trust in disclosing these experiences and communicating about their symptoms. Cultural context is essential in the screening and assessment process to promote accurate diagnoses and buy-in to PCPs' treatment recommendations. Further research is needed to explore PCP and patient characteristics that impact cross-cultural interactions in primary care settings that use the Integrated Health Care model. Identifying these factors will enable researchers to determine the presence of other factors beyond race and ethnicity that influence the patient-provider alliance and treatment outcomes as they relate to White and BIPOC patients. Direct assessment of biases in these settings may impede efforts to advance racial and health equity. Alleviating stress and promoting equitable representation in behavioral health diagnoses and treatment for BIPOC patients in the United States will require incorporating best practices and identifying implicit factors that exacerbate inequities. Knowledge of covert and overt factors at each level of the system creates an opportunity to study mechanisms that, if not accounted for, exacerbate the marginalization of BIPOC patients and hinder efforts to achieve equitable health for all persons.

Funding Details

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,313,979 with <10 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.

Disclosure Statement

There are no financial conflicts of interest or benefits that have arisen from the direct application of this research.

Acknowledgments

We would like to acknowledge the contributions of Pamela Walter, MFA, for her role in editing this manuscript in preparation for submission. We would like to extend our gratitude to Abby Adamczyk, MLIS, Graduate Medical Education Librarian, for her expertise in search strategies, enabling our research team to conduct an exhaustive literature search and formulate our proposed research topic. Finally, we would like to acknowledge the contributions of Dr. Jacelyn Biondo and Dr. Rachel Ludeke for their role as informal consultants in reflexivity in qualitative research and processing with the research team and for the role of their personal lived experience in data analysis and conceptualization.

References

Atewologun, D. (2018). Intersectionality theory and practice. *Oxford research encyclopedia of business and management*, 1-20. https://doi.org/10.1093/acrefore/9780190224851.013.48

Adams, A., Realpe, A., Vail, L., Buckingham, C. D., Erby, L. H., & Roter, D. (2015). How doctors' communication style and race concordance influence African-Caribbean patients when disclosing depression. *Patient education and counseling*, *98*(10), 1266–1273. https://doi.org/10.1016/j.pec.2015.08.019

Baghikar, S., Benitez, A., Fernandez Piñeros, P., Gao, Y., & Baig, A. A. (2019). Factors impacting adherence to diabetes medication among urban, low income Mexican-Americans with diabetes. *Journal of Immigrant and Minority Health*, *21*(6), 1334–1341. https://doi.org/10.1007/s10903-019-00867-9

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bingham, A. J. (2023). From data management to actionable findings: A five-phase process of qualitative data analysis. *International Journal of Qualitative Methods*, *22*, 1–11. https://doi.org/10.1177/16094069231183620

Blair, I. V., Havranek, E. P., Price, D. W., Hanratty, R., Fairclough, D. L., Farley, T., Hirsh, H. K., & Steiner, J. F. (2013). Assessment of biases against Latinos and African Americans among primary care providers and community members. *American Journal of Public Health*, *103*(1), 92–98. https://doi.org/10.2105/AJPH.2012.300812

Bogart, L. M., Ojikutu, B. O., Tyagi, K., Klein, D. J., Mutchler, M. G., Dong, L., Lawrence, S. J., Thomas, D. R., & Kellman, S. (2021). COVID-19 related medical mistrust, health impacts, and potential vaccine hesitancy among Black Americans living with HIV. *Journal of Acquired Immune Deficiency Syndromes*, *86*(2), 200–207. https://doi.org/10.1097/QAI.0000000000002570

Borraz, S., Zeitoun, V., & Dion, D. (2021). Subjectivity and reflexivity: The contributions of countertransference to interpretative research. *Recherche et Applications En Marketing (English Edition)*, *36*(1), 65–81. https://doi.org/10.1177/2051570720942384

Carel, H. (2011). Phenomenology and its application in medicine. *Theoretical medicine and bioethics*, *32*, 33-46. https://doi.org/10.1007/s11017-010-9161-x

Chenail, R. (2011). Interviewing the investigator: Strategies for addressing instrumentation and researcher bias concerns in qualitative research. *The Qualitative Report*, *16*, 255–262. https://doi.org/10.46743/2160-3715/2011.1051

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of women in culture and society*, *38*(4), 785-810. https://doi.org/10.1086/669608

Cleveland Manchanda, E. C., Molina, M. F., & Rodriguez, R. M. (2021). Racial equity in crisis standards of care-reassuring data or reason for concern? *JAMA Network Open*, *4*(3), Article e214527. https://doi.org/10.1001/jamanetworkopen.2021.4527

Collingridge, D. S., & Gantt, E. E. (2019). Republished: The quality of qualitative research. *American journal of medical quality*, *34*(5), 439-445. doi: 10.1177/1062860619873187

Cuevas, A. G., & O'Brien, K. (2019). Racial centrality may be linked to mistrust in healthcare institutions for African Americans. *Journal of Health Psychology*, *24*(14), 2022–2030. https://doi.org/10.1177/1359105317715092

DiAngelo, R. (2016). White fragility. *Counterpoints*, *497*, 245–253. http://www.jstor.org/stable/45157307

Dickman, S. L., Gaffney, A., McGregor, A., Himmelstein, D. U., McCormick, D., Bor, D. H., & Woolhandler, S. (2022). Trends in health care use among Black and White persons in the US, 1963-2019. *JAMA Network Open*, *5*(6), Article e2217383. https://doi.org/10.1001/jamanetworkopen.2022.17383

Dodgson J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation: Official Journal of International Lactation Consultant Association*, *35*(2), 220–222. https://doi.org/10.1177/0890334419830990

Dovidio, J. F., Penner, L. A., Albrecht, T. L., Norton, W. E., Gaertner, S. L., & Shelton, J. N. (2008). Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. *Social Science & Medicine*, *67*(3), 478–486. https://doi.org/10.1016/j.socscimed.2008.03.019

Eggly, S., Barton, E., Winckles, A., Penner, L. A., & Albrecht, T. L. (2015). A disparity of words: racial differences in oncologist-patient communication about clinical trials. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *18*(5), 1316–1326. https://doi.org/10.1111/hex.12108

Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old issues, new directions. *Du Bois Review: Social Science Research on Race*, *8*(1), 115–132. https://doi.org/10.1017/S1742058X11000130Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): A diagnostic meta-analysis. *Journal of General Internal Medicine*, *22*(11), 1596–1602. https://doi.org/10.1007/s11606-007-0333-y

Health Resources & Services Administration. (2023). *Behavioral Health Workforce, 2023 Brief*. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf

Henry, T. L., Jetty, A., Petterson, S., Jaffree, H., Ramsay, A., Heiman, E., & Bazemore, A. (2020). Taking a closer look at mental health treatment differences: Effectiveness of mental health treatment by provider type in racial and ethnic minorities. *Journal of Primary Care & Community Health*, *11*, 1–9. https://doi.org/10.1177/2150132720966403

Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., Mattox, G., & Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services*, *11*(4), 357–368. https://doi.org/10.1037/a0038122

Jaiswal, J., & Halkitis, P. N. (2019). Towards a more inclusive and dynamic understanding of medical mistrust informed by science. *Behavioral Medicine*, *45*(2), 79–85. https://doi.org/10.1080/08964289.2019.1619511

Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing primary care contributions to behavioral health: A cross-sectional study using medical expenditure panel survey. *Journal of Primary Care & Community Health*, *12*, 1–6. https://doi.org/10.1177/21501327211023871

Jones, R. D., Chapman, C. H., Holliday, E. B., Lalani, N., Wilson, E., Bonner, J. A., Movsas, B., Kalnicki, S., Formenti, S. C., Thomas, C. R., Jr, Hahn, S. M., Liu, F. F., Jagsi, R., & Society of Chairs of Academic Radiation Oncology Programs (SCAROP) (2018). Qualitative assessment of academic radiation oncology department chairs' insights on diversity, equity, and inclusion: Progress, challenges, and future aspirations. *International Journal of Radiation Oncology, Biology, Physics*, *101*(1), 30–45. https://doi.org/10.1016/j.ijrobp.2018.01.012

Kalpokaite, N., & Radivojevic, I. (2019). Demystifying qualitative data analysis for novice qualitative researchers. *The Qualitative Report*, *24*(13), 44–57. https://doi.org/10.46743/2160-3715/2019.4120

Landoll, R. R., Maggio, L. A., Cervero, R. M., & Quinlan, J. D. (2019). Training the doctors: A scoping review of interprofessional education in Primary Care Behavioral Health (PCBH). *Journal of Clinical Psychology in Medical Settings*, *26*(3), 243–258. https://doi.org/10.1007/s10880-018-9582-7

Marchlin, S. R., United States. Agency for Healthcare Research and Quality., Medical Expenditure Panel Survey, United States. Agency for Healthcare Research and Quality., & Medical Expenditure Panel Survey. (2006). *Expenses for a hospital emergency room visit, 2003*. Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality.

Malâtre-Lansac, A., Engel, C. C., Xenakis, L., Carlasare, L., Blake, K., Vargo, C., Botts, C., Chen, P. G., & Friedberg, M. W. (2020). Factors influencing physician practices' adoption of behavioral health integration in the United States: A qualitative study. *Annals of Internal Medicine*, *173*(2), 92–99. https://doi.org/10.7326/M20-0132

Mentz, R. J., Greiner, M. A., Muntner, P., Shimbo, D., Sims, M., Spruill, T. M., Banahan, B. F., Wang, W., Mwasongwe, S., Winters, K., Correa, A., Curtis, L. H., & O'Brien, E. C. (2018). Intentional and unintentional medication non-adherence in African Americans: Insights from the Jackson Heart Study. *American Heart Journal*, *200*, 51–59. https://doi.org/10.1016/j.ahj.2018.03.007

Mulvaney-Day, N., Marshall, T., Downey Piscopo, K., Korsen, N., Lynch, S., Karnell, L. H., Moran, G. E., Daniels, A. S., & Ghose, S. S. (2018). Screening for behavioral health conditions in primary care settings: A systematic review of the literature. *Journal of General Internal Medicine*, *33*(3), 335–346. https://doi.org/10.1007/s11606-17-4181-0

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2022). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical Teacher*, *45*(3), 241–251. https://doi.org/10.1080/0142159X.2022.2057287

Patel, S. R., Schnall, R., Little, V., Lewis-Fernández, R., & Pincus, H. A. (2014). Primary care professional's perspectives on treatment decision making for depression with African Americans and Latinos in primary care practice. *Journal of Immigrant and Minority Health*, *16*(6), 1262–1270. https://doi.org/10.1007/s10903-013-9903-8

Piot, M. A., Attoe, C., Billon, G., Cross, S., Rethans, J. J., & Falissard, B. (2021). Simulation training in psychiatry for medical education: A review. *Frontiers in Psychiatry*, *12*, Article 658967. https://doi.org/10.3389/fpsyt.2021.658967

Piot, M. A., Dechartres, A., Attoe, C., Jollant, F., Lemogne, C., Layat Burn, C., Rethans, J. J., Michelet, D., Cross, S., Billon, G., Guerrier, G., Tesniere, A., & Falissard, B. (2020). Simulation in psychiatry for medical doctors: A systematic review and meta-analysis. *Medical Education*, *54*(8), 696–708. https://doi.org/10.1111/medu.14166

Powell, J. A. (2007). Structural racism: Building upon the insights of John Calmore. *North Carolina Law Review*, *86*(3), Article 8. https://scholarship.law.unc.edu/cgi/viewcontent.cgi?article=4312&context=nclr

Rogers, H. L., Dumenci, L., Epstein, R. M., & Siminoff, L. A. (2019). Impact of patient gender and race and physician communication on colorectal cancer diagnostic visits in primary

care. *Journal of Women's Health*, *28*(5), 612–620. https://doi.org/10.1089/jwh.2018.6961

Saha, S., & Beach, M. C. (2020). Impact of physician race on patient decision-making and ratings of physicians: A randomized experiment using video vignettes. *Journal of General Internal Medicine*, *35*(4), 1084–1091. https://doi.org/10.1007/s11606-020-05646-z

Saldaña, J. (2021). *The Coding Manual for Qualitative Researchers*. (4th Ed.). Sage Publications

Sampson, H. (2004). Navigating the waves: The usefulness of a pilot in qualitative research. *Qualitative Research*, *4*(3), 383-402. https://doi.org/10.1177/1478794104047236

Siniscalchi, K. A., Broome, M. E., Fish, J., Ventimiglia, J., Thompson, J., Roy, P., Pipes, R., & Trivedi, M. (2020). Depression screening and measurement-based care in primary care. *Journal of Primary Care & Community Health*, *11*, 1–11. https://doi.org/10.1177/2150132720931261

Smajic, E., Avdic, D., Pasic, A., Prcic, A., & Stancic, M. (2022). Mixed methodology of scientific research in healthcare. *Acta Informatica Medica*, *30*(1), 57–60. https://doi.org/10.5455/aim.2022.30.57-60

Starfield B. (2012). Primary care: An increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012. *Gaceta Sanitaria*, *26*(Suppl. 1), 20–26. https://doi.org/10.1016/j.gaceta.2011.10.009

Substance Abuse and Mental Health Services Administration. (2022). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health* (HHS Publication No. PEP22-07-01-005, NSDUH Series H-57). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf

Terlizzi, E. P., & Schiller, J. S. (2022). Mental health treatment among adults aged 18-44: United States, 2019-2021. *NCHS Data Brief*, (444), 1–8. https://doi.org/10.15620/cdc:120293

van Mens-Verhulst, J., & Radtke, H. L. (2006). Intersectionality and health care: support for the diversity turn in research and practice. *Unpublished paper*.

Vora, S., Dahlen, B., Adler, M., Kessler, D. O., Jones, V. F., Kimble, S., & Calhoun, A. (2021). Recommendations and guidelines for the use of simulation to address structural racism and implicit bias. *Simulation in Healthcare: Journal of the Society for Simulation in Healthcare*, *16*(4), 275–284. https://doi.org/10.1097/SIH.0000000000000591

Walker, E. R., Cummings, J. R., Hockenberry, J. M., & Druss, B. G. (2015). Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatric Services*, *66*(6), 578–584. https://doi.org/10.1176/appi.ps.201400248

Wilson, C., Janes, G., & Williams, J. (2022). Identity, positionality and reflexivity: Relevance and application to research paramedics. *British Paramedic Journal*, *7*(2), 43–49. https://doi.org/10.29045/14784726.2022.09.7.2.43

Notes on Contributor

Shane´ J. Gill, is a Research Fellow in the Department of Family & Community at Thomas Jefferson University. Dr. Gill has over a decade of clinical experience and is currently a student in the Quantitative Methods program at the University of Pennsylvania. She recently completed a certificate in Innovations for Substance Use from Johns Hopkins University. Her interest are in predictors that increase disparities in behavioral health diagnoses for marginalized populations and treatment in primary care. She aims to create technological

intereventions that can increase access to and improve behavioral health outcomes for marginalized populations globally.

Brooke Mauriello, is a clinical research coordinator in the Department of Family & Community Medicine at Thomas Jefferson University.. After completing her undergraduate degree in psychology at Rowan University, she pursued a master's in public health from Temple University, with a concentration in social and behavioral science. While in the master's program, she developed an interest in health equity and substance use research. Brooke is also an experienced data manager for an Overdose Fatality Review Team, contributing significantly to the understanding and mitigation of overdose fatalities.

ORCID

Shane´ J. Gill, https://orcid.org/0000-0003-0352-3723
Brooke Mauriello, https://orcid.org/0009-0009-2787-9389

Appendix A

Table A1 Themes and Definitions

THEME	CODES	DESCRIPTION
Eurocentrism-Americanism	Culture, Western Culture, and National Culture	Attitudes, beliefs, values, and behaviors that reinforce the notion of Whiteness as superior and the norm or frame of reference for which all other cultural groups are to be compared. In the context of American culture, (an extension of European culture), this frame of reference is defined as "White, male or masculine, cisgender, and heteronormative"; assessment, diagnosis, and treatment in medicine and behavioral health for all groups are influenced by this frame of reference and ultimately, a Eurocentric or White worldview.
Cultural Alignment	Provider Identity, Bias, Explicit Bias, and Identity Concordance	Providers' individual expression of their identity (e.g., race, ethnicity, nationality, sex, gender, language, spirituality, religion, creed, education status, marital status, etc.) and perspectives on their alignment with Eurocentrism or practices that may enforce White, male or masculine, cisgender, heteronormativity as superior to all other groups. The degree of alignment with Eurocentrism or the dominant cultural ideology shapes implicit and explicit biases and interactions between patients and providers.
Structural Inequity	Systemic Factors, Institutional Factors, Departmental Factors, and Practice Factors	Inherent or habitual and unintended rules, regulations, practices, and processes that contribute to inequities in access, quality, overall care, and total health outcomes for Black, Indigenous, People of Color (BIPOC). Structural Inequity is the byproduct of systems that are not culturally informed and consequently, fail to deliver or minimally deliver care that is both culturally sensitive and relevant to diverse patient populations, exacerbating inequity observed for vulnerable groups.
Patient First-Wellness Centered	Therapeutic Approach, Assessments, Formal Assessments, Informal Assessments, Socioeconomic Characteristics, General Pop Referrals, BIPOC Pop Referrals, and Diagnostic Approaches	The Patient First-Wellness Centered Approach emphasizes the individuality of the patient first and necessity of core tenants of humanism; the providers' focus is on the totality of the patient, using formal and informal means to explore factors that may influence his/her/their welfare and well-being. The welfare and well-being of the patient is the providers' priority but is defined by and in collaboration with the patient. Contrary to the Patient-Centered Approach, cultural competence is continuously developed and is an iterative process throughout the duration of the therapeutic relationship; This requires knowledge of racial/ethnic and socioeconomic and sociocultural factors that impact patients' welfare and well-being and for these aspects to be incorporated at the onset of treatment.
Cultural Framework	Culturally Sensitive Approaches, Cultural Humility, Communication, and Verbal Communication	A Cultural Framework is an orientation adopted by a system or systems that seeks to obtain knowledge from a variety of sources to continually be informed on the patient populations served. One of these sources of knowledge must include the patients; through this knowledge, practices and processes in treatment are adapted to (1) meet the needs of the patient as an individual, (2) reflects knowledge of unique cultural factors that shape presentation and expression of concerns, and (3) incorporates these cultural factors in treatment as deemed appropriate by the patient (e.g., language, recognition of behavioral health conditions and terminology, relational

		patterns, positionality, religious/spiritual practices, use of traditional or indigenous treatment, etc.) to ensure care is both sensitive and responsive to their needs.
Systemic Outlook	Systemic Progress, Systemic Changes, Care Coordination, and Bx Health Referrals	Providers perspectives and prospectives on factors that impact behavioral health treatment for patients, their ability to render care at each level of the system, and strategic changes to improve processes within the system to enhance access and quality of care for all patients.
Relationship Dynamics	Social Identity, Patients' Attitudes and Beliefs, and Individual Identity	Factors that impact the therapeutic rapport between patients and Behavioral Health Consultants (BHCs), collaboration, and decision-making in treatment.

Table A2 Abbreviated and Full Quotes

THEME	INTERVIEW	ABBREVIATED QUOTE	FULL QUOTE
Eurocentrism-Americanism	Interview 4	"I define culture by commonalities that are identified by language, commonalities and shared experiences that others may not be familiar with, I also define culture by how people do life, how they show up and how they do life, and that these are agreed upon values and mores and customs... You can take two couples, put them in the same room, and they're different."	I define culture by commonalities that are identified by language, commonalities and shared experiences that others may not be familiar with, I also define culture by how people do life, how they show up and how they do life, and that these are agreed upon values and mores and customs. So you have culture, then you have subculture and sub subculture. I even break it down, honestly, Dr. Gill, to when I'm meeting with patients and their relationships, I tell them, your relationship is a culture. You can take two couples, put them in the same room, and they're different. One culture, they enjoy movies and nights out, another relationship, they enjoy dancing and walking their dog. That's a culture. So I think it's an agreed upon shared customs, values, the way people do life, worldview that are very identifiable and are different.
Eurocentrism-Americanism	Interview 1	"...Mental health I think is so nuanced... talking about cultures, maybe different countries or places in that regard may have a different relationship in terms of what mental health is or what mental health care looks like."	Right. And mental health I think is so nuanced, and also different cultures may have, I'm [inaudible 00:05:28] talking about cultures, maybe different countries or places in that regard may have a different relationship in terms of what mental health is or what mental health care looks like. And so I think being mindful of depression and anxiety and how it shows up in the United States and maybe our understanding, it may be different in a different country as well, or different place.
Eurocentrism-Americanism	Interview 2	"We have always and historically tried to align medicine with white cisgender care, and that's not right... So, I really do think that it's up to individual providers to use the tools that we currently have that we need to use, and using them in a way that is filled with cultural humility, that is filled with conversation and clarity,	So I don't think that the screening tools that we currently have incorporates that for the most part. And I'm going to going to speak more broadly. I don't think it's a Jefferson specific. I think that this is a void across healthcare in general, is that we have always and historically tried to align medicine with white cisgender care, and that's not right.

		and not taking a number as the only data point... So, I think that those single data points that we use, it is a point, I get it. We need some form of measurement to do good work, but that shouldn't be the only form of measurement..."	And I think that we're moving away from that, but I also think, especially as a behavioral health professional, that's even more delayed. Because the words in which we use to describe things, how we describe things, past traumas, cultural traumas, historical traumas aren't brought into the conversation. So I really do think that it's up to individual providers to use the tools that we currently have that we need to use, and using them in a way that is filled with cultural humility, that is filled with conversation and clarity, and not taking a number as the only data point. But I don't think screening tools provide that, or at least I haven't come across one that has provided that yet.
Cultural Alignment	Interview 2	"But to me, sometimes my conscious bias is that I'm representing white authoritarian medicine. I think I have an unconscious... Not an unconscious. I have a very conscious bias that I also represent, and when people hear social worker specifically from the BIPOC community, that that can be very scary... I could represent something that's very reassuring to the BIPOC community, but I tend to take the lens that I represent kind of what's wrong with these systems."	I subscribe and I believe, and even when I teach, that's actually one of my initial slides, is the labeling of both conscious and unconscious biases that we have. And I think that when I think about I'm sure I have plenty of unconscious biases that could be or seen, conscious biases, I tend to be along the lines of what I've previously said where I'm probably a little bit more even aware of what I represent. And that can be a biased approach, because that's not fair to the person that I'm meeting with. I could represent their sister. I could represent their mom, their best friend. But to me, sometimes my conscious bias is that I'm representing white authoritarian medicine. I think I have an unconscious... Not an unconscious. I have a very conscious bias that I also represent, and when people hear social worker specifically from the BIPOC community, that that can be very scary. I've had patients say to me, "Don't take my kid." Things like that. And I validate that, because that is real. We come from implicitly racist and biased systems, and I think that sometimes I think appropriate... I

			really don't. But again, I don't think I give every individual the benefit, because I could represent something that isn't harming. I could represent something that's very reassuring to the BIPOC community, but I tend to take the lens that I represent kind of what's wrong with these systems.
Cultural Alignment	Interview 4	"God's working on me...I remember this one really showed me my bias. So elderly woman from a Latin country just arrived in America a few years ago after her husband passed away... She didn't speak English at all. So, her son was there and he was translating or interpreting... And I said, 'Well, can I ask what caused you to come?'... "[She said] 'and I think maybe on that day I was feeling a little down, but I'm fine. I don't really need your help.' And then she just was so adorable and Latin and full of laughter. And Dr. Gill, it was like shame came over me. I just said, "I cannot believe I was so", and I think I couldn't connect with her."	I would say my bias would be what comes to mind, it is sad, but I'm working on it. God's working on me. If... And this is all because of communication, and I'm a big person on clarity. So if I'm not able to receive a lot of clarity about what they're saying because of a thick accent, then I make assumption, no, not assumptions. This was a good one. I remember this one really showed me my bias. So elderly woman from a Latin country just arrived in America a few years ago after her husband passed away in their mother country that she moved here after husband passed to live with adult children, all adults. She's a grandmother. She didn't speak English at all. So her son was there and he was translating or interpreting. So I had to do the screenings with him, and then he translated, and so she would give him the answers. But when I started to just assess, it just felt like a lot of work. I was exhausted, and I just didn't realize it at first, because that's what it was, I asked because she kept saying, "Yeah, I'm fine. I'm fine. It's a few things." She was so sweet and she would just do this. And so then my thought was, okay, all of this work, translate all of this work, and she's fine. And I said, "Why are you here?" And I said, "Well, can I ask what caused you to come?" And then she said, "Oh, I was just having a doctor's visit." Her son, of course, is telling me, "I was just having a doctor's visit", and she was asking me these questions, and I answered, "And I think maybe on that day I was feeling a little down, but I'm fine. I don't really need your help."

			And then she just was so adorable and Latin and full of laughter. And Dr. Gill, it was like shame came over me. I just said, "I cannot believe I was so", and I think I couldn't connect with her. I was connecting with her through her son. And then hearing she didn't have any issues. And it was just really her doctor doing a thorough job and saying, "Well, hey, go talk to this person who's here." And she even said, "If I need you, I'll come, but I don't need anything. I'm fine. I dance. I stay in my room. I'm good." And so it turned out to be a very short visit, but it was so lighthearted at the end, she would've never known what was on the inside of me, but it was something I had to sit with, and I'm not happy about that.
Cultural Alignment	Interview 1	"I try to check myself about this, but I think maybe there's empathy that may be potentially missing, and it's not like I go out of my way, I don't care, but it's just our lived experiences are different. So maybe I have a hard time understanding what it's like to be a Black person or what it's like to be an Indigenous person because that's just not my lived experience. But I try to find overlap or commonality, I guess, to foster that empathy."	I try to check myself about this, but I think maybe there's empathy that may be potentially missing, and it's not like I go out of my way, I don't care, but it's just our lived experiences are different. So maybe I have a hard time understanding what it's like to be a Black person or what it's like to be an Indigenous person because that's just not my lived experience. But I try to find overlap or commonality, I guess, to foster that empathy. And I feel like I'm pretty good at it, just being a therapist, I feel like I need to be. I feel like I've kind of mastered that skill in some way. And also, I don't know, there's someone that could have my identity and for whatever reason, personality wise, we just don't click. And there's someone that could be like BIPOC identity and we're like, oh, I feel like I think like this person. And so there could be overlap there. But I think it's just different lived experience and I may have a hard time a conceptualizing it or empathizing, I would say.
Cultural Alignment	Interview 3	"I think, like I said before, I think it's just being careful not to make assumptions about their life experience and treat	Dr. Shane' Gill: In what way has or does patients' race or ethnicity impact or influence how you might assess and

		everybody as equally as I can, with honor and respect.”	understand their symptoms or their concerns? Speaker 2: I think, like I said before, I think it's just being careful not to make assumptions about their life experience and treat everybody as equally as I can, with honor and respect. And you just never know a person's history. I mean, this woman from Haiti, she lost everything, but she was a medical doctor in Haiti. Here, she's got nothing. Dr. Shane’ Gill: Yeah. Speaker 2: She's living in someone's basement. And I can only say that I aim to be as unbiased as I can. I'm sure I'm affected by biases, but I aim for equity and treating people as equally as possible.
Cultural Alignment	Interview 2	“This actually just triggered a whole [other] memory of a patient I worked with through the pandemic, through the murder of George Floyd, Breonna Taylor. And she said to me... At the end, we had worked with her PCP, who's also white, cisgender female. And she had said, "Mollie, I had almost stopped seeing all white providers. But the way that you and the other provider just talked to me, tried to understand where I was coming from, even though you knew you could never understand it, helped me through."	I have also had patients say, "Mollie, you seem like a great person. I want someone that looks like me." And I say, "I honor and I respect that. Let me help you out with this. Please know though that I'm always here for you." You know what I mean? "So don't feel like we need to close the door." This actually just triggered a whole nother memory of a patient I worked with through the pandemic, through the murder of George Floyd, Breonna Taylor. And she said to me... At the end, we had worked with her PCP, who's also white, cisgender female. And she had said, "Mollie, I had almost stopped seeing all white providers. But the way that you and the other provider just talked to me, tried to understand where I was coming from, even though you knew you could never understand it, helped me through." And I think, again, this isn't for me to... I think sometimes again, we can get on our high horse. It's not always that case, right? I want to give balance. There's plenty of times where patients want specific, again, that cultural identity. And if

			that's, again, seeing someone that looks like them, then that's what I'm going to do. I'm not going to say, "Oh no, stay with me. I've helped this many people before." No, it's not about that. It's about what they want in that moment in time.
Cultural Alignment	Interview 1	"Well, I'm thinking of screeners that I administer, like the PHQ-9 and the GAD-7 and the PCL-5. I don't know. I guess I'm thinking about, I have one patient and they're Portuguese speaking and I have to be mindful of how certain things are translated and received, and so I'm thinking about language differences and maybe leading to certain language barriers."	Dr. Shane' Gill: From your perspective and considering that definition then, how does culture shape current screening and assessment practices for patients that have behavioral health concerns? Speaker 2: Well, I'm thinking of screeners that I administer, like the PHQ-9 and the GAD-7 and the PCL-5. I don't know. I guess I'm thinking about, I have one patient and they're Portuguese speaking and I have to be mindful of how certain things are translated and received, and so I'm thinking about language differences and maybe leading to certain language barriers.
Structural Inequity	Interview 3	"I don't work under one roof, and there's so many different services. It's more of a splintered experience here at... and so it's not... We're kind of all splintered, and so it's not as easy to just refer someone to a social worker, to be honest with you."	I can't really tell you much because I work out of five or six offices, most of them virtual except for one, and the one I'm at in person, we don't have a social worker. So it's really through just messaging that I may say, "Maria, do you have recommendations for transportation?" I don't work under one roof, and there's so many different services. It's more of a splintered experience here at [my organization], and so it's not... Where I used to work, there was a social worker literally in the same building down the hall. There was a lawyer, there was a nutritionist, there was a diabetes educator, there is a legal team. We're kind of all splintered, and so it's not as easy to just refer someone to a social worker, to be honest with you.
Structural Inequity	Interview 2	"… I also know that those systems are very difficult to navigate, and they're historically difficult to navigate, again, for systemic, conscious and unconscious, racist and bias forming of it. Who should	So I am biased towards integrated care. I will share that. And I find that referring out can lead to, again, these ongoing stigmatization and lack of resources. So whenever I refer out, I always remind that I am still here, because

		receive services and who should not receive services?"	I want to honor them in connecting them to the resource that they want. But I also know that those systems are very difficult to navigate, and they're historically difficult to navigate, again, for systemic, conscious and unconscious, racist and bias forming of it. Who should receive services and who should not receive services? So when I think about what I do is more along the lines of health equity, I try to align that.
Relationship Dynamics	Interview 1	"... for Black identifying individuals, there is definitely a larger population there and they've talked about how, or I've heard a few times that mental health is not valued or recognized in my family or with my friends or other Black identifying individuals. So, it's really helpful to be able to have someone to talk about it."	And this is, like I said before, it doesn't really strike me as super different than other groups, but reasons that people with those identities have come in and they talked to me would be, I think it's a lot of times the health issues, the work stress, maybe family stuff going on. I think a lot of times what I've heard patients say is it's really helpful to speak about my, I don't really work with so many Indigenous identifying individuals, but for Black identifying individuals, there is definitely a larger population there and they've talked about how, or I've heard a few times that mental health is not valued or recognized in my family or with my friends or other Black identifying individuals. So it's really helpful to be able to have someone to talk about it.
Relationship Dynamics	Interview 4	"...Certain cultures that it's a stigma to receive mental health...if you're disenfranchised or on the margin, just that anxiety about being seen, having to unpack. I think that if certain individuals come in with that mindset, you may not get accuracy because whatever those agreed upon terms and customs and ideas can influence how a person shows up in the session and even answers."	Okay. How does culture shape that? Well, immediately what I think about is willingness to open up and share if you have certain cultures that it's a stigma to receive mental health or if you're disenfranchised or on the margin, just that anxiety about being seen, having to unpack. I think that if certain individuals come in with that mindset, you may not get accuracy because whatever those agreed upon terms and customs and ideas can influence how a person shows up in the session and even answers. And then on the flip side so, I think, yeah, either way, whether it's a willingness and openness, a yes, I've arrived and I'm grateful to be here, or the other side of the

			spectrum where it's more just very hard to open up and to warm up because of these ideas. Can I give you an example?
Relationship Dynamics	Interview 1	"...I think, and maybe I'm overthinking it, but I think socially speaking it's like, oh, you're a white man and there's a lot of privilege attached to that, and I think it's kind of sometimes it can be like, okay, well I'm going to trust you as this knowledgeable resource. Maybe not knowledgeable is the right word, but as this person because of the power association, and other times it's like you don't share my identity, so I can't trust you or I can't open up to you."	I think it could work in my favor in some ways and then it could be a disadvantage in other ways. I think, and maybe I'm overthinking it, but I think socially speaking it's like, oh, you're a white man and there's a lot of privilege attached to that, and I think it's kind of sometimes it can be like, okay, well I'm going to trust you as this knowledgeable resource. Maybe not knowledgeable is the right word, but as this person because of the power association, and other times it's like you don't share my identity, so I can't trust you or I can't open up to you.
Patient-first Wellness-centered Approach	Interview 4	"... I am that mediator for them. So, if they're virtual, I put them on a three-way, and I'm that bridge for them to help them get comfortable speaking to entities they don't know... I do the referral during the session, and I let the patient know the social worker will be reaching out to them within 24, 48 hours so that they know that there's a team that they're being heard, and I'm on it immediately...So just doing a lot of that bridge work and helping them build comfort and even coaching them, patients who, yeah, so definitely being a three-way, being a bridge, connecting with resources."	Also, sometimes if there are resources that I'm aware of that are very unique, and I know that that's one of the major barriers or the causations, we just make time and make that the session calling places, if they're nervous or they're struggling with communication or comprehension, I am that mediator for them. So if they're virtual, I put them on a three-way, and I'm that bridge for them to help them get comfortable speaking to entities they don't know. But then also in person, we get on the computer together. So literacy, I have a couple of patients who are in their forties, never got their GED, but they're very nervous, very ashamed. So just doing a lot of that bridge work and helping them build comfort and even coaching them, patients who, yeah, so definitely being a three-way, being a bridge, connecting with resources. I'm a big believer that part of my being a therapist is a case manager. I feel like that's an integral part. If you remove the trigger or the barrier, maybe you lessen the depression. Depression didn't just come out of nowhere, so I even do job searching with them. So a lot of even job readiness, role play and get them connected. A couple of my elderly patients who were very

			lonely, isolated in the session, we've gone on to the adult day center, looked at some of their Facebook pages and how much fun they're having. Then I've called the places with the patient there and I've talked on their behalf and encouraged them to kind of speak up a little bit. And all of those are different types of concerns.
Patient-first Wellness-centered Approach	Interview 2	"... And when I use things, I use universal we. I use a universal we. I use a very humanistic approach. So even if we are coming from different backgrounds and cultures, and that can be seen, again, right off the bat by the color of my skin or by my gender, that I still go back to the fundamental principles of our physiology, and how we are always trying to cope and manage different situations. And I explore that through that way, using a contextual interview."	But that's also building rapport, because patients feel comfortable in that sense. I'm trying to think, what else do I do that is intentional? I think just how I ask the question, the curiosity. The interest in them as a person here and now. And when I use things, I use universal we. I use a universal we. I use a very humanistic approach. So even if we are coming from different backgrounds and cultures, and that can be seen, again, right off the bat by the color of my skin or by my gender, that I still go back to the fundamental principles of our physiology, and how we are always trying to cope and manage different situations. And I explore that through that way, using a contextual interview.
Patient-first Wellness-centered Approach	Interview 1	"... I'll give different measures, like the PHQ-9 for depression, the GAD-7 for anxiety, PCL-5 for trauma. Those are the ones I mainly give. And then we have an intake, I guess smart phrases [inaudible 00:13:53]. And so, we have what brings you here, what are your presenting issues, what are your goals? And so based off of all those questions, both quantitatively and qualitatively, like I said, I usually make an assessment."	Well, both qualitatively and quantitatively, like I said, I'll give different measures, like the PHQ-9 for depression, the GAD-7 for anxiety, PCL-5 for trauma. Those are the ones I mainly give. And then we have an intake, I guess smart phrases [inaudible 00:13:53]. And so we have what brings you here, what are your presenting issues, what are your goals? And so based off of all those questions, both quantitatively and qualitatively, like I said, I usually make an assessment.
Patient-first Wellness-centered Approach	Interview 2	"So, I just think there's times where you could have someone who has a 26, and you've assessed for safety, and they are safe. They have passive SI. And I think these people are inadvertently typically institutionalized for, again,	Evidence-based might say, "Okay, you have a score between 15 and 22 on your PHQ-9. That instantly means you would benefit from medication management, talk therapy, as well as behavioral interventions." I still present that to them, because their symptoms are

		racist and biased reasons versus having a conversation. How demonizing is that? If I were to be like, "Well, you're scoring a two here on suicidality. Let's discuss a safety plan and let's get you to crisis."	still there. But they might say, "You know what, Mollie? I just want to make sure that I can do X, Y, and Z." "Okay, well, let's do that, and then follow up with me next time you see your PCP in a month or two, and we'll see how it's going. And if it's not going well, come back and see me." Because people live. It's as if we think we're the, how do people live without us? They live. They survive. Our brains are meant to help us to survive. So I just think there's times where you could have someone who has a 26, and you've assessed for safety, and they are safe. They have passive SI. And I think these people are inadvertently typically institutionalized for, again, racist and bias reasons versus having a conversation. How demonizing is that? If I were to be like, "Well, you're scoring a two here on suicidality. Let's discuss a safety plan and let's get you to crisis."
Cultural Framework	Interview 2	"...When I think about historical traumas within healthcare of the BIPOC population, how many times has a white person said, 'I'm the expert, you are not. And I am going to not tell you X, Y, and Z'? And it still happens today. So, trying to dismantle that authoritarian approach is actually probably something that I'm quite intentional about, and more so with BIPOC patients."	I have enough information to know that I have to address these things in a very formal way to create a level of rapport, and to address it right off the bat for many BIPOC patients that I see. And I think that that's also too where I come down to you are the expert, because again, when I think about historical traumas within healthcare of the BIPOC population, how many times has a white person said, "I'm the expert, you are not. And I am going to not tell you X, Y, and Z"? And it still happens today. So trying to dismantle that authoritarian approach is actually probably something that I'm quite intentional about, and more so with BIPOC patients, because I believe... And it's not for everyone, but I believe that that does need to be addressed in order for a level of safety.

Cultural Framework	Interview 1	"...I guess I'm thinking about just my identity and maybe how it's being received as a white cisgender man and working with patients... I see religion comes up a lot and faith and spirituality, and so I think one question is have you had thoughts about killing yourself or harming yourself, and how in a religious way that could be seen as maybe potentially insulting or like I would never do that because of my faith-based practice. And so, I think being mindful of that."	I don't know. I guess I'm thinking about just my identity and maybe how it's being received as a white cisgender man and working with patients who may have differing identities, or even sometimes the same identity as well, and what could come up based off of that. It's pretty broad. I guess I'm having a hard time thinking of specific examples right now, but I mean, I see religion comes up a lot and faith and spirituality, and so I think one question is have you had thoughts about killing yourself or harming yourself, and how in a religious way that could be seen as maybe potentially insulting or like I would never do that because of my faith-based practice. And so I think being mindful of that.
Cultural Framework	Interview 4	"... So, before they became available in Epic, we used to just have the screening tools as papers, and I would give them to the patient. And I noticed some of them would struggle, and I used to be a school teacher, so now I ask... So, in terms of the administration, when they're with me and I administer to them, I use language such as small, medium, large, or not at all, rather than whatever it is."	So I'll answer in three parts. The first is how I administer, I'm always sensitive that not everyone is able to read and comprehend because the language is very clinical. So before they became available in Epic, we used to just have the screening tools as papers, and I would give them to the patient. And I noticed some of them would struggle, and I used to be a school teacher, so now I ask, well, now I don't have to because they can access through Epic and answer on their own. But when they're sitting with me and they haven't completed the screenings, or if they have, and I see their score, I'll just mention it. So in terms of the administration, when they're with me and I administer to them, I use language such as small, medium, large, or not at all, rather than whatever it is.
Cultural Framework	Interview 4	"... I'm a big believer in asking to be educated and not assuming that when they're saying certain cultural references or customs, I say, "You know what? That's interesting. Educate me a little bit about that. I just want to hear more about that... So, I would say that I just trying to be sensitive, and that changes how I sit, where I sit, proximity. A lot	So I would say that that approach, if, let's see what else? I'll ask. I'm a big believer in asking to be educated and not assuming that when they're saying certain cultural references or customs, I say, "You know what? That's interesting. Educate me a little bit about that. I just want to hear more about that." Or not making assumptions about whether holidays. So I would say

		of these make a difference even with looking."	that I just trying to be sensitive, and that changes how I sit, where I sit, proximity. A lot of these make a difference even with looking.
Systemic Outlook	Interview 2	"I do think that there needs to be an intentional dismantling of white, heteronormative, cisgender male culture…But you have to give power. When we think about power and control, if the people in power aren't sharing the power, then it doesn't matter what happens down below."	Well, I think it comes multifaceted. I think that we need to have patients... I know we have patient advisory committees, but I really do think that patients need to sit on the board, period. Not just wealthy individuals sitting on the board. I think it comes from both places, but I do think that there needs to be an intentional dismantling of white, heteronormative, cisgender male culture. You know what I mean? But it has to come here, because it can come from below. But you have to give power. When we think about power and control, if the people in power aren't sharing the power, then it doesn't matter what happens down below. And I think that that happens on a macro level. I think it happens on a micro level of teaching this humility, of being, saying, and doing. I come with expertise, but I am not the expert in you.
Systemic Outlook	Interview 2	"But to me, a good medicine program would be like, 'Yeah, we can train you how to do all your facts, but let's actually train you how to be a human. Let's do that and let's really confront those things.'"	Yeah. So I mean, sure, we can discuss good programs. But to me, a good medicine program would be like, "Yeah, we can train you how to do all your facts, but let's actually train you how to be a human. Let's do that and let's really confront those things." But that's not just medicine. And I think we're, and I'm using the universal we. We as mental health professionals generally get that training to some extent, but not all healthcare professionals do. And I think that too, you need to have your smarts to be a doctor. I'm not worried that they can't look up and do the research. But it's like, how are you a person?
Systemic Outlook	Interview 4	"Definitely researching I would say how [my organization] could begin to partner with entities within Philadelphia who want to provide upliftment in	Definitely researching I would say how [my organization] could begin to partner with entities within Philadelphia who want to provide upliftment in these particular

		these particular populations…So I would say maybe one [preventative protective factor] is to just kind of check the pulse and maybe get some surveys about patients specifically with that in those needs.”	populations. I know that there was a lot going on during the quarantine and right after the police brutality, and there was just such an incredible saturation of Zoom meetings and webinars and cultural, and I just sometimes when things are trendy, but I'm a believer in staying consistent. And so I don't want it to just be the trend until the next something happens. So sometimes the next something doesn't have to happen if you have preventative protective factors in place. So I would say maybe one is to just kind of check the pulse and maybe get some surveys about patients specifically with that in those needs. Also, I do know that [my organization] does have some kind of financial assistance program, and I do refer my patients to them, but it doesn't seem like they're making good headway with that.