“Too much pain, doctor!”: The exploration of culture and gender-mediated factors on the detection and management of psychosocial distress in primary care clinical encounters.

Madison Leggatt

Department of Family Medicine

McGill University, Montreal

August 2023

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Master of Science in Family Medicine.

ABSTRACT

Background: In Canada, inequities in mental health care are particularly evident among ethnoculturally diverse patients, who have higher rates of undiagnosed mental health conditions than patients from the dominant ethnocultural groups in Canada. Additionally, despite the same clinical presentation, women are more likely than men to be diagnosed with depression. Family physicians play an important role in the assessment and management of psychosocial distress, but the varied presentations of psychosocial distress by ethnoculturally diverse patients may contribute to the under detection and misdiagnosis. Yet some family physicians are recognized by colleagues as having expertise in the detection and management of psychosocial distress in intercultural clinical encounters. Understanding how these family physicians detect psychosocial distress across cultures and gender will help to provide other physicians with pragmatic strategies for accurately detecting and managing psychosocial distress in the context of intercultural encounters.

Objectives:

1) To explore family physicians' perceptions on how culture and gender-mediated factors affect the presentation of psychosocial distress in intercultural clinical encounters.
2) To identify the cues and strategies used to recognize and elicit causes of psychosocial distress by family physicians in intercultural clinical encounters.

Methods: A qualitative descriptive study was conducted in Montreal, Quebec. Through purposive snowball sampling, 13 "expert" family physicians were interviewed individually. The interviews probed participants' perceptions on the role of culture and gender-related factors in

the clinical encounter. A thematic analysis of the data was guided by the Framework Method, using the Patient-Centered Clinical Method as an analytic framework.

Results: In intercultural clinical encounters, family physicians intentionally explore a patient's cultural frame of mental health to situate potential presentations of psychosocial distress. Strategies for exploring and contextualizing a patient's cultural frame include: 1) Explicitly asking patients about their culture; 2) Pleading ignorance to elicit illness narratives; and 3) Finding shared humanity. Reflecting cultural frames and gendered norms surrounding mental health, patients often present with vague and somatic complaints in primary care. Strategies for managing these presentations include: 1) Organic due diligence first; 2) Introducing practical aspects of well-being; and 3) Adopting appropriate authoritative strategies. Although family physicians did not initially identify any explicit dimension of gender in their strategies, the role of gender is particularly evident in help-seeking behaviour and access to care and the development of care plans.

Conclusion: Experienced family physicians have identified explicit strategies to elicit cultural presentations of psychosocial distress and they exhibit more tacit strategies when considering gender-mediated factors. To appropriately account for these factors in the clinical encounter, a nuanced approach to eliciting the patient's narrative is needed to prevent the perpetuation of harmful culture and gender-based stereotypes. Principles of family medicine, including continuity of care and finding common ground, help facilitate this. The experiential skill of "expert" family physicians can help adapt the patient-centered clinical method into pragmatic

strategies to improve the detection and management of psychological distress in intercultural encounters.

RÉSUMÉ

Contexte : Au Canada, les inégalités en matière de soins de santé mentale sont particulièrement évidentes parmi les patients d'origines ethnoculturelles diverses. Ceux-ci ont un taux plus élevé de troubles de santé mentale non-diagnostiqués que les patients issus des groupes ethnoculturels dominants au Canada. De plus, malgré les mêmes représentations cliniques, les femmes sont plus susceptibles d'être diagnostiquées avec une dépression par rapport aux hommes. Les médecins de famille jouent un rôle important dans l'évaluation et la prise en charge de la détresse psychosociale. Cependant, les représentations variées de la détresse psychosociale chez les patients issus de la diversité ethnoculturelle peuvent contribuer à la sous-investigation et à l'erreur de diagnostic. Toutefois, certains médecins de famille sont reconnus par leurs collègues comme ayant une expertise dans la détection et la prise en charge de la détresse psychosociale lors des rencontres cliniques interculturelles. Comprendre comment ces médecins de famille détectent la détresse psychosociale en fonction de la culture et du genre aidera à fournir aux autres médecins des stratégies pragmatiques pour détecter et prendre en charge de manière optimale la détresse psychosociale en contexte de rencontres interculturelles.

Objectifs :

1) Explorer les perceptions des médecins de famille quant à l'influence des facteurs culturels et de genre sur les représentations de la détresse psychosociale lors des rencontres cliniques interculturelles.

2) Identifier les indices et les stratégies utilisés par les médecins de famille en contexte de rencontres cliniques interculturelles pour reconnaître et recueillir les causes de la détresse psychosociale.

Méthode : Une étude descriptive qualitative a été réalisée à Montréal, Québec. Grâce à un échantillonnage boule de neige, 13 médecins de famille « experts » ont participé à des entrevues individuelles. Ces entrevues ont exploré les perceptions des participants quant au rôle de la culture et des facteurs liés aux genres lors des rencontres cliniques. Une analyse thématique des données a été réalisée, guidée par la Framework Method, utilisant l'approche clinique centrée sur le patient comme cadre analytique.

Résultats : Lors des rencontres cliniques interculturelles, les médecins de famille vont intentionnellement explorer le contexte culturel du patient quant à la santé mentale afin de connaître les représentations possibles de la détresse psychosociale. Les stratégies explicites pour explorer et contextualiser le cadre culturel du patient sont : 1) interroger explicitement les patients sur leur culture, 2) Feindre l'ignorance pour recueillir une histoire de la maladie, et 3) Trouver des points communs. En raison des cadres culturels et des normes de genres qui entourent la santé mentale, les patients se présentent souvent avec des plaintes vagues et somatiques dans les soins primaires. Les stratégies de prise en charge de ces représentations comprennent : 1) l'examen approprié des plaintes physiques, 2) présenter des aspects pratiques d'amélioration du bien-être, et 3) adopter des stratégies d'autorité appropriées. Même si les médecins de famille n'identifient pas une dimension explicite du genre dans leurs stratégies, le rôle du genre devient évident dans la recherche de soins par les patients et dans le développement de plans de soins.

Conclusion : Les expériences et représentations de la détresse psychosociale sont influencées par des facteurs relatifs à la culture et au genre. Afin de prendre en compte ces facteurs de

manière appropriée lors des rencontres cliniques, il est nécessaire d'adopter une approche nuancée pour éliciter l’expérience du patient de manière à éviter la perpétuation de stéréotypes préjudiciables. Les principes de la médecine familiale, notamment la continuité des soins et la recherche d'un terrain d'entente, facilitent cette démarche. Les compétences expérientielles des médecins de famille peuvent se traduire par des stratégies pragmatiques visant à améliorer la détection et la prise en charge de la détresse psychologique lors des rencontres interculturelles.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

First and foremost, I would like to thank my supervisors, Dr. Alayne Adams and Dr. Jeannie Haggerty. Your guidance, support, and encouragement have been instrumental in helping me navigate the peaks and valleys of this masters. I would also like to thank my committee member, Dr. Isabelle Leblanc. Your experiences and insight are at the heart of this project, and I cannot thank you enough for sharing this with me. I am grateful to all of you for welcoming me onto this team and helping me grow into the researcher I am today.

I would also like to thank Anna-Maréva Ferville for all of your help with this project and the insights you contributed, merci ! Thank you to the physicians who participated in this study; I hope you find your experiences and humility reflected in this work.

The community of professors, students, and staff from the Department of Family Medicine and St. Mary's Research Centre were also invaluable to my experience, exposing me to new ideas and providing countless opportunities to further develop my research capacities. I would also like to acknowledge the generous funding provided by the Department of Family Medicine, the Canadian Institutes of Health Research, and St. Mary's Research Centre and Foundation that helped make this thesis possible.

Last but not least, I am extremely grateful for the love and support of my parents and siblings. You have been there for me every step of the way. Thank you for always believing in me, even when I doubted myself. But most of all, thank you for always reminding me to see the bigger picture. To my friends, you helped make Montreal feel like a home away from home, which I am forever grateful for. I can't wait to see what you all go on to accomplish.

"GO PLACIDLY AMID THE NOISE AND THE HASTE"

Max Ehrmann

CONTRIBUTION OF AUTHORS

The master's candidate, Madison Leggatt, completed this thesis under the supervision of Dr. Alayne Adams, Dr. Jeannie Haggerty, and Dr. Isabelle Leblanc. The impetus for this project stems from Dr. Leblanc's clinical experiences as a family physician. The conceptualization and design of this study was completed by all four members. Madison completed all data collection in English and Ms. Anna-Maréva Ferville, the research assistant, completed all data collection in French. Data analysis and interpretation was primarily led by Madison, with insight and feedback provided by all members of the research team. This thesis was written entirely by Madison Leggatt, with editorial assistance and feedback from all members of the research team.

INTRODUCTION

Inequities in mental health care are a persistent challenge in Canada (Islam et al., 2018; Kirmayer & Jarvis, 2019; Public Health Agency of Canada, 2018). Research finds that ethnocultural and racialized groups access mental health care services significantly less than their white counterparts and experience higher rates of undiagnosed mental health conditions (Chiu et al., 2018).[1] Inequitable outcomes are also evident when comparing women and men, with women being more likely than men to be diagnosed with depression, despite the same clinical presentation (Afifi, 2007; Seidler, Rice, Dhillon, et al., 2019; World Health Organization, 2002). In addition to the structural and systemic factors that lead to and perpetuate these inequities, various sociocultural factors are at play (Kirmayer & Jarvis, 2019).

Culture and gender are of particular interest, given their role in shaping conceptualizations of mental health, help-seeking behaviours, presentations of distress, and expectations of care (Afifi, 2007; Cross & Bloomer, 2010; Gopalkrishnan, 2018; Kirmayer, 2001; Kirmayer et al., 2011; Kirmayer & Jarvis, 2019; Kiropoulos et al., 2005; Rice et al., 2020; Seidler, Rice, Dhillon, et al., 2019; Seidler, Rice, Ogrodniczuk, et al., 2019; Sleath & Rubin, 2002; Yasui et al., 2017). The interaction between an individual's cultural background and gender is not the only dynamic impacting their health experience – also at play is the clinician's background and the cultural assumptions underlying Western medicine manifested within the clinical encounter (Lehti et al., 2010). Together, these factors can create challenges for the appropriate detection, diagnosis, and treatment of mental health challenges (Afifi, 2007; Brownhill et al., 2003; Emslie et al., 2007; Seidler, Rice, Ogrodniczuk, et al., 2019).

[1] These groups are not mutually exclusive.

Primary care is a critical entry point into the healthcare system for mental health challenges with most cases of mild and moderate depression and or anxiety diagnosed and managed at this level (Clatney et al., 2008; Islam et al., 2018; Kiropoulos et al., 2005; Sleath & Rubin, 2002). This is particularly apparent among immigrants. Based on data from the Canadian Community Health Survey, it was found that 57.89% of immigrants interviewed consulted their family doctor for a mental health need in the past year (Islam et al., 2018). It follows that primary care physicians play an important role in the detection and treatment of psychosocial distress (Clatney et al., 2008; Islam et al., 2018; Kiropoulos et al., 2005; Sleath & Rubin, 2002).

An area of concern that is especially pertinent in culturally diverse populations is the management of complex cases in which the primary complaint is presented as somatic in nature, but upon further investigation, an underlying mental health issue is identified. Such cases are ubiquitous in primary care as depression, anxiety, and somatic complaints (bodily manifestations of distress) present together more often than not (Bridges & Goldberg, 1987; Gonzales, 2018; Lowe et al., 2008; Simon et al., 1996). Despite this reality, research indicates that physicians lack pragmatic strategies for approaching intercultural encounters, especially those relating to mental health (Fleury et al., 2012; Islam et al., 2018; Rosenberg et al., 2007).

A promising solution is to integrate culture and gender considerations into the patient-centered clinical method, which is a widely applied systematic approach for exploring and contextualizing the presentation of illness and disease in primary care (Rosenberg et al., 2006, 2007; Stewart et al., 2003, 2013). It is taught during undergraduate medical training and graduate family medicine residency training and is particularly well-suited for the contextualization, diagnosis, and management of the wide range of health problems that are characteristic of primary care (Stewart et al., 2003, 2013). However, little specific attention has focused on how

to manage culturally and gender-mediated expressions of mental health (Lehti et al., 2010; Yasui et al., 2017). Many primary care clinicians lack pragmatic strategies for accurately detecting and treating psychosocial distress in the context of intercultural encounters (De Maesschalck et al., 2011; Lehti et al., 2010; Rosenberg et al., 2007). As a consequence, clinicians may overgeneralize psychosocial distress within certain cultural groups; or conversely, ignore it altogether, treating its somaticized manifestations instead (Cross & Bloomer, 2010; García-Sierra et al., 2020). In either scenario, risks of under-detection, misdiagnosis, inappropriate treatment of and or over-investigation of somatic symptoms can occur (Cross & Bloomer, 2010; García-Sierra et al., 2020; Kirmayer, 2001; Kiropoulos et al., 2005; Ryder et al., 2002).

Purpose

This study is the first phase in a larger study that will explore how culture and gender-mediated factors affect the presentation of psychosocial distress, and identify the cues and strategies used by experienced primary care physicians in intercultural clinical encounters to accurately detect and manage mental health concerns. In the subsequent phase, the identified strategies and cues will be incorporated into a training module to complement and strengthen training in the patient-centered clinical method for family medicine residents and continuing education programs for physicians.

Objectives

1) To explore family physicians' perceptions on how culture and gender-mediated factors affect the presentation of psychosocial distress in intercultural clinical encounters.

2) To identify the cues and strategies used to recognize and elicit causes of psychosocial distress by family physicians in intercultural clinical encounters.

LITERATURE REVIEW

This section provides an overview of the literature on mental health care, with a focus on how culture and gender-mediated factors impact the expression and detection of psychosocial distress in primary care encounters. First, the state of mild-moderate mental health challenges in Canada is presented. Subsequently, the relationship between culture and mental health is explored, followed by the relationship between gender and mental health.[2] The implications of these relationships on the expression and presentation of psychosocial distress are emphasized. Following, the relevance of primary care and family physicians in the provision of mental health is presented.

Section 1: Mental Health in Canada

In Canada, access to mental health care remains a challenge (Islam et al., 2018; Kirmayer & Jarvis, 2019; Moroz et al., 2020; Public Health Agency of Canada, 2018). In 2018, 5.3 million individuals reported needing help for a mental health challenge, with 43.8% reporting the care they received was inadequate or that they did not access care (Statistics Canada, 2019). Challenges to accessing care are attributed to several factors such as the lack of available mental health services at both the primary and tertiary level, poor integration among the existing services, and challenges navigating the healthcare system (Moroz et al., 2020). Access to care is also impeded by cultural and linguistic barriers (Moroz et al., 2020).

Unmet mental health care needs have been found to be particularly high among ethnic groups in Canada (Chiu et al., 2018). A population health survey in Ontario found that South Asian, Black, and Chinese individuals are significantly less likely than their White counterparts

[2] Notably, culture and gender interact to affect mental health outcomes and care but are presented separately for ease of reading.

to access care and have higher rates of undiagnosed mental health conditions, after adjusting for age, sex, and immigration status (Chiu et al., 2018). In addition to the barriers listed above, different conceptualizations and stigmatizations of mental health affect help-seeking behaviours and interactions in the clinical encounter (Islam et al., 2018; Kirmayer & Jarvis, 2019; Moroz et al., 2020). In instances of intercultural clinical encounters, this can pose challenges to the detection and diagnosis of mental health challenges (Lehti et al., 2010). For example, the varied presentations and expressions of psychosocial distress may be one of the factors that contribute to the under-detection of mental health challenges (Kirmayer, 2001; Kiropoulos et al., 2005; Lehti et al., 2010; Rosenberg et al., 2006, 2007).

Differences in mental health needs and the diagnosis of health outcomes are also seen between women and men (Denton et al., 2004; Kerr & Kerr, 2001). On average, women experience worse health than men (Denton et al., 2004). The causal determinants of these differences in health outcomes are complex, with gender-based differences in terms of differential exposure and vulnerability to the social determinants of health (Denton et al., 2004). Women's health tends to be shaped more by structural and psychosocial factors, whereas men's is shaped more by behavioural determinants (Denton et al., 2004). However, for mental health, psychosocial factors such as environmental and family stress are the most predictive of health outcomes (Denton et al., 2004). In terms of diagnosis, research has found that women are 2x as likely as men to be diagnosed with a mental health disorder, which may be partially explained by culturally- and gender-biased screening tools used to detect depression (Kerr & Kerr, 2001).

Section 2: Culture and Mental Health

2.1 Overview

Culture is an interactive process that shapes and reflects knowledge, values, and interactions within and throughout communities, networks, and systems (Kirmayer, 2001, 2012; Kleinman & Benson, 2006; Yasui et al., 2017). It shapes and is shaped by larger political, economic, and social factors as well as by age, gender, and social class (Kleinman & Benson, 2006). As such, within a culture, there is considerable internal diversity (Kirmayer, 2001, 2012; Kleinman & Benson, 2006; Yasui et al., 2017).

In relation to health, culture influences explanatory model(s) of illness, help-seeking behaviour, communication, and treatment preferences, among other factors (Andermann, 2010; Cross & Bloomer, 2010; Gopalkrishnan, 2018; Kirmayer, 2001, 2012; Kirmayer & Jarvis, 2019; Kiropoulos et al., 2005; Lehti et al., 2010; Sleath & Rubin, 2002; Yasui et al., 2017). As such, one's culture will shape understandings of what constitutes mental health and well-being (Andermann, 2010; Cross & Bloomer, 2010; Gopalkrishnan, 2018; Kirmayer, 2001; Kirmayer, 2012; Kirmayer & Jarvis, 2019; Kiropoulos et al., 2005; Lehti et al., 2010; Sleath & Rubin, 2002; Yasui et al., 2017). This is evident in the conceptualization and terms used across cultures to convey equivalents of "depression" (Lehti et al., 2010; Patel, 2001; Sleath & Rubin, 2002). Conceptualizations might include an emotional illness, rather than a mental illness (Sleath & Rubin, 2002). Different terms might include "thinking too much" or nerves (Lehti et al., 2010; Patel, 2001; Sleath & Rubin, 2002). These differences in conceptualizations and terms are scarcely captured in diagnostic guidelines nor taught in medical school, impeding the appropriate detection and diagnosis of mental health challenges among ethnoculturally diverse patients (Kerr & Kerr, 2001; Lehti et al., 2010; Rosenberg et al., 2007).

2.2 Approaches

The role of sociocultural factors in shaping mental health has been explored extensively in the fields of psychiatry and anthropology (Kirmayer & Minas, 2000; Kleinman et al., 1978; Patel, 2001). Early work in psychiatry focused on cross-cultural differences in mental disorders and their prevalence (Kirmayer & Minas, 2000). Symptoms and behaviours by cultural groups that were not recognized nor well understood were pathologized and classified as culture-bound syndromes (Kirmayer & Minas, 2000). Furthermore, the implicit Western cultural assumptions underpinning disease categorizations and diagnostic tools were overlooked (Kirmayer & Minas, 2000; Kleinman et al., 1978; Patel, 2001). Recognizing this category fallacy and the failure to situate symptoms and behaviours within their sociocultural context, a transition to the new cross-cultural psychiatry was made (Kirmayer & Minas, 2000; Kleinman et al., 1978; Patel, 2001). Within this approach, more attention is given to the role of culture and the diversity within cultures (Kirmayer & Minas, 2000; Kleinman et al., 1978; Patel, 2001).

Recognizing the need for healthcare professionals to be more aware of the role of culture in clinical care, several approaches/models aimed at integrating cultural considerations into care approaches have been proposed. Cultural competency and more recently, cultural safety, are prominent models (Brascoupé & Waters, 2009; Curtis et al., 2019; Kirmayer & Jarvis, 2019). Cultural competency is often conceptualized as a spectrum, with cultural awareness at one end, followed by cultural sensitivity, cultural humility, and cultural competency at the other anchor point (Brascoupé & Waters, 2009; Curtis et al., 2019; Kirmayer & Jarvis, 2019).[3] Cultural awareness aims to raise attention to the differences between cultures and the impact of such cultural differences on health (Curtis et al., 2019). However, the emphasis on differences creates

[3] Many different iterations of cultural competency models exist with variations in the "ranks" used.

an “othering” of cultures that differ from the dominant culture seen within society (Curtis et al., 2019). Cultural sensitivity builds on this by necessitating the need to respect these differences and consider one’s own culture (Curtis et al., 2019). Cultural humility focuses on assessing and recognizing one’s own culture and its inherent biases, while also pushing clinicians to explore the patient’s cultural frames (Curtis et al., 2019). Cultural competency focuses on healthcare workers learning about other cultures and building their competency to work with them (Curtis et al., 2019; Kirmayer & Jarvis, 2019). However, this model implies a static notion of culture such that a health professional can master it, creating an implicit power dynamic (Curtis et al., 2019; Kirmayer, 2012; Kleinman & Benson, 2006). Moreover, it fails to address the effects of the healthcare professional’s culture, the subculture of Western medicine, and is centred on the healthcare professional (Curtis et al., 2019; Kirmayer, 2012; Kirmayer & Jarvis, 2019). Coined by a Māori nurse in New Zealand, cultural safety emphasizes that all parties must reflect on their *own* cultures and implicit biases as well as the power dynamics and the larger systemic barriers at play and how these all interact to shape the provision of care and overall care experience (Brascoupé & Waters, 2009; Curtis et al., 2019; Kirmayer & Jarvis, 2019). Thus, cultural safety requires critical reflection at both the clinical and structural levels. Given this shift towards critical reflection of power dynamics, there is debate concerning whether or not cultural safety is the next point on the cultural competency spectrum, or better reflected as a paradigm shift (Brascoupé & Waters, 2009).

2.3 Expressions and Presentations

The expression and presentation of psychological distress is an area that has received considerable attention in cross-cultural research, with particular attention to the somatization of psychological distress (Aragona et al., 2005; Bhatt et al., 1989; Bragazzi et al, 2015; Bridges &

Goldberg, 1987; Garcia et al., 2020; Gonzales, 2018; Gureje et al., 1997; Khoo et al., 2012; Kirmayer, 2001; Kirmayer & Robbins, 1996; Patel, 2001; Ryder et al., 2002; Sheikh & Furnham, 2012; Simon et al., 1996). Somatization refers to the use of physical/bodily complaints to express psychological distress (Bridges & Goldberg, 1987; Patel, 2001). Somatization has been problematized as an issue specific to certain ethnocultural groups, developing countries, and or immigrants (Aragona et al., 2005; Bragazzi et al, 2015; Patel, 2001; Sheikh & Furnham, 2012). A study by Aragona and colleagues (2005) found somatization to be significantly more prevalent among South/Central American immigrants, when compared to Caucasian, Asian, and African immigrants, after controlling for sex, age, education, and length of stay in the new country. However, other studies have found the use of bodily complaints to express distress to be prevalent across all cultures, inclusive of Western cultures (Bridges & Goldberg, 1987; Lehti et al., 2010; Mallinson & Popay, 2007; Patel, 2001; Simon et al., 1996). Based on data from a World Health Organization study on Somatization in Primary Care, no cultural trends or sex differences were found concerning somatization when using the somatic symptom index (Gureje et al., 1997). Other research indicates that the use of somatic complaints is common in the early stages of a mental health challenge, with more "classic" symptoms of depression (loss of interest) emerging as an illness progresses and thus is recognized by a patient (Patel, 2001).

The consequences of misapplying somatic forms of distress in clinical and research settings have been highlighted; somatic complaints may be ignored, resulting in the under-detection, misdiagnosis, and under-treatment of mental health challenges (Garcia et al., 2020; Gonzales, 2018; Yasui et al., 2017). Alternatively, they can be over-attributed to mental health problems, leading to the over-investigation and over-medicalization of expressions of distress (Garcia et al., 2020; Gonzales, 2018; Yasui et al., 2017).

Section 3: Gender and Mental Health

3.1 Overview

Culture also shapes gender as gender is a social construct, grounded in cultural and societal norms (Afifi, 2007; Johnson et al., 2009; Lindsay et al., 2019; Lindsay & Kolne, 2020; Spitzer, 2005). Through processes of socialization, women and men learn "appropriate" behaviours and ways to interact based on traditional notions of femininity and masculinity (Seidler, Rice, Dhillon, et al., 2019).[4] As such, within and across cultures, there are myriads of gendered roles that ascribe to cultural and societal norms (Afifi, 2007; Andermann, 2010; Johnson et al., 2009; Spitzer, 2005).

In relation to health, sex and gender interact to affect physical and mental health outcomes, illness experiences, help-seeking behaviours, communication patterns, and treatment preferences, among other factors (Afifi, 2007; Andermann, 2010; Johnson et al., 2009; Spitzer, 2005; WHO, 2002). For example, differences are seen in the frequency in which mental health care is obtained in primary care services, with women consulting their family physician more frequently than men (Afifi, 2007; Rice et al., 2020). Notably, not accessing services does not necessitate that men experience fewer problems, but rather may reflect different internalized gender norms (Brownhill et al., 2003; Emslie et al., 2007; Rice et al., 2020; Seidler, Rice, Ogrodniczuk, et al., 2019). Expressions and presentations of distress will also differ based on different internalized notions of femininity and masculinity and what is deemed acceptable (Brownhill et al., 2003; Lehti et al., 2010; Sleath & Rubin, 2002). As such, mental health concerns are often not directly expressed, requiring physicians to be sensitive to subtle cues of distress (Emslie et al., 2007; Seidler, Rice, Dhillon, et al., 2019). However, research finds that

[4] Masculinity and femininity exist on spectrums and the use of the plural terms 'masculinities' and 'femininities' is more inclusive and appropriate.

physicians often miss these cues and differentially explore mental health complaints based on universal stereotypes of how women and men are thought to traditionally present and express distress (Brownhill et al., 2003; Sleath & Rubin, 2002).

3.2 Approaches

In order to appropriately account for and address the various ways gender-based roles and norms affect individuals' mental health and well-being, approaches that do not consider the influence of gender should be avoided (Afifi, 2007). Recognizing this role of sex and gender, various approaches to care are beginning to emerge. Gender-sensitive care is an increasingly prominent approach in the field of healthcare, emerging from the field of nursing (Miers, 2002). A gender-sensitive care approach addresses sex and gender-based differences and inequities in morbidity and mortality, while also situating care and its provision in its socio-political context (Lindsay et al., 2019; Lindsay & Kolne, 2020; Miers, 2002). This approach emphasizes that healthcare professionals must critically reflect on how their own understandings of sex and gender shape the clinical encounter and the quality of care they provide (Lindsay et al., 2019; Lindsay & Kolne, 2020; Miers, 2002). However, as gender-sensitive care remains a novel area of research, the actual strategies used to provide gender-sensitive care remain underdeveloped (Lindsay & Kolne, 2020). Further attention is needed to situate gender-tailored approaches within cultural contexts to ensure appropriate care (Emslie et al., 2007).

Recent work focusing on men's health has made calls for male-centred/male-sensitive approaches, with an explicit call for shifting the narrative surrounding masculinity (Rice et al., 2020; Seidler, Rice, Ogrodniczuk, et al., 2019). Specifically, a strength-based approach to men's mental health should be implored, creating space for the full spectrum of emotions, behaviours, and experiences of men (Rice et al., 2020; Seidler, Rice, Ogrodniczuk, et al., 2019). To be

properly incorporated into practice, attention needs to be placed on the physicians' own gender biases and their role in fostering an environment where men feel comfortable disclosing challenges and expressing themselves emotionally (Rice et al., 2020; Seidler, Rice, Ogrodniczuk, et al., 2019).

3.3 Expressions and Presentations

Gender also impacts the way mental health challenges are presented and expressed within the clinical encounter and can impede the detection and diagnosis of mental health challenges (Afifi, 2007; Brownhill et al., 2003, 2005; Emslie et al., 2007; Seidler, Rice, Ogrodniczuk, et al., 2019; Spitzer, 2005). Research indicates that both women and men often struggle to find the right vocabulary to discuss their emotional challenges and are unsure of what is considered "legitimate" to bring forward in an appointment (Emslie et al., 2007). In a study by Emslie and colleagues (2007) on gender differences and similarities in discussing depression and communication strategies, it was found that both women and men struggled to identify and express their mental health challenges. Consequently, this impacted patients' ability to engage in the clinical encounter and understand what their physicians were seeking to assess.

However, gender differences appear to emerge more prominently in the expression of distress (Brownhill et al., 2005; Emslie et al., 2007; Lehti et al., 2010). In line with dominant notions of femininity, women are often found to be more forthcoming with their mental health challenges and more emotional (Afifi, 2007; Brownhill et al., 2005; Emslie et al., 2007; Spitzer, 2005). In contrast, but aligning with dominant notions of masculinity, men are often found to be more closed-off about their mental health challenges and present more externalizing signs of anger or irritability (Afifi, 2007; Brownhill et al., 2005; Emslie et al., 2007; Spitzer, 2005). A study by Danielson and Johansson (2005) on the gendered expressions of depression found both

women and men reported physical symptoms. However, women also tended to discuss emotional aspects of their distress whereas men focused on physical symptoms. Thus, it is not surprising that when women and men present with the same clinical presentation of distress, women are more likely to be diagnosed with depression than men (Afifi, 2007; Seidler, Rice, Dhillon, et al., 2019). This is problematic for both women and men, as women's distress may be inappropriately treated and overmedicalized, while men's distress may be overlooked and underdiagnosed (Afifi, 2007; Brownhill et al., 2003; Emslie et al., 2007; Seidler, Rice, Ogrodniczuk, et al., 2019). Part of the challenge in diagnosing depression may be related to the idea that depression may be experienced differently for genders and that social roles and norms may push women and men to different types of depressions.

Evidently, if gender norms and their resulting consequences are not accounted for, issues of under-detection, misdiagnosis, and inappropriate treatment may arise (Afifi, 2007; Seidler, Rice, Ogrodniczuk, et al., 2019). Thus, physicians require sensitivity to both implicit and explicit expressions of distress, but also communication strategies to foster a safe and conducive environment where patients feel comfortable to share their experiences. Gender-tailored approaches are necessary to transcend stereotypes that prevent the appropriate detection and diagnosis of psychosocial distress (Emslie et al., 2007).

Section 4: Primary Care

4.1 Overview

Primary care is a key entry point into the healthcare system for people experiencing mental health problems (Clatney et al., 2008; Kiropoulos et al., 2005; Sleath & Rubin, 2002). Approximately 80% of Canadians seek mental health care from their family physician and primary care is where the majority of mild to moderate mental health challenges can be managed

(Moroz et al., 2020). Yet mental health challenges are often inaccurately diagnosed and less than 25% of family physicians report feeling prepared to meet severe mental health challenges (Moroz et al., 2020).

4.2 Expressions and Presentations

Research indicates that depression, anxiety, and somatization are the most common mental health problems presented in primary care, as somatic complaints are often used to express underlying psychosocial distress (Bridges & Goldberg, 1987; Gonzales, 2018; Lowe et al., 2008; Simon et al., 1996). At the same time, primary care providers struggle to accurately detect and treat psychological distress and somatization (Bridges & Goldberg, 1987; Clatney et al., 2008; Gonzales, 2018; Rosenberg et al., 2006; Sleath & Rubin, 2002). Consequently, the under-detection and treatment of mental health challenges and or the over-investigation of somatic complaints may arise and compromise the quality of care provided (Bridges & Goldberg, 1987; Cross & Bloomer, 2010; Garcia et al., 2020; Gonzales, 2018; Kirmayer et al., 2011; Yasui et al., 2017). Thus, there is a call for further training of primary care providers in the detection and treatment of psychological distress and its various presentations (Dune et al., 2018; Emslie et al., 2007; Kerr & Kerr, 2001; Kirmayer et al., 2011; Rosenberg et al., 2006; Sleath & Rubin, 2002; Yasui et al., 2017).

4.3 Approaches

A promising approach to improve the provision of intercultural mental health care is to integrate ethnocultural and gender considerations into the patient-centered clinical method, which is a widely applied and systematic approach for exploring and contextualizing the presentation of illness and disease in primary care (Rosenberg et al., 2006, 2007; Stewart et al.,

2013). The patient-centered clinical method is comprised of four interacting components: 1) exploring health, disease, and the illness experience; 2) understanding the whole person; 3) finding common ground; and 4) enhancing the patient-physician relationship (Stewart et al., 2013). It has been linked to better symptom resolution and fewer diagnostic and specialist referrals (Little et al., 2001; Stewart et al., 2000). Evidently, the patient-centered method aims to take a whole-person approach to care, considering both proximal and distal factors that influence the illness experience (Stewart et al., 2013). However, there has been far less attention, if any, on how culture can affect disease manifestation and the presentation of distress (Rosenberg et al., 2007; Stewart et al., 2013). As a result, physicians lack pragmatic strategies for accurately detecting and treating culturally and gender-mediated presentations of psychological distress in the context of intercultural encounters (Rosenberg et al., 2007).

METHODS

Research Team

The research team is comprised of a family physician (Dr. Isabelle Leblanc), two professors from the Department of Family Medicine at McGill (Drs. Alayne Adams and Jeannie Haggerty), the graduate student (Ms. Madison Leggatt), and a research assistant (Ms. Anna-Maréva Ferville).

Research Paradigm

The impetus for this project stems from the clinical experience of the physician on the research team, who noted that culturally-mediated presentations of distress may be under-detected, misdiagnosed, or over-investigated with existing screening tools and usual interviewing techniques. Although a repertoire of cultural cues and implicit communication strategies exist among experienced physicians serving culturally diverse practices, there is no formal mechanism for conveying this acquired knowledge to future family physicians. Thus, in line with the goal of developing a training module complementary to training provided on the patient-centered method, a pragmatic research paradigm guided this work (Allemang et al., 2022; Kaushik & Walsh, 2019).

A pragmatic paradigm is a theoretical framework that guides the conceptualization and scientific inquiry of practical real-world issues (Allemang et al., 2022; Kaushik & Walsh, 2019). Experience and action are central to the paradigm; experience both situates and instigates action (Allemang et al., 2022; Kaushik & Walsh, 2019). Thus, through experience with a problem, individuals meaningfully understand and act on the problem (Allemang et al., 2022; Kaushik & Walsh, 2019). In research, real-world experience helps to meaningfully understand the problem and orientate the objectives (Allemang et al., 2022; Kaushik & Walsh, 2019). Depending on the

problem, qualitative, quantitative, or mixed methods may be used (Allemang et al., 2022; Kaushik & Walsh, 2019).

Reflexivity

As an individual and researcher, my cultural background, gender, and education, among other factors, shape this research. Specifically, as a white Canadian-born woman, my positionality puts me in a place of privilege. Various social structures that produce inequalities, such as racism and classism, provide me with unearned advantages (Nixon, 2019). Recognizing these structures helps increase my awareness to both the positions of unearned advantage and disadvantage, but more importantly, the structures that create them (Nixon, 2019).

As a graduate research student in the Department of Family Medicine at McGill, I was able to easily build rapport with participants as most physicians interviewed are affiliated with the department. In building the initial rapport, I often explained to participants that I was not a medical student nor a resident, signalling to the physicians I was less familiar with certain clinical aspects. Consequently, physicians described their clinical encounters and the strategies they employ in detail, facilitating rich descriptions. In all interviews, there was an inherent power dynamic in terms of knowledge and occupation, favouring the participants and their expertise. This was favourable for fostering a judgement-free atmosphere where physicians could talk freely. As all interviews were conducted in person or over Zoom video calls, my ethnicity and gender also likely impacted the discussion of these topics to an extent.

A prevailing Western biomedical worldview is implicit in the overall study and the findings. Specifically, Western understandings and conceptualizations of mental health are the frame of reference. Additionally, gender is only discussed as a binary construct. Conscious efforts were made not to stereotype or oversimply cultural groups or genders, but rather to

highlight how culture and gender-mediated factors and experiences need to be recognized and accounted for in clinical practice.

Methodology

This study utilized a qualitative descriptive methodology in seeking to comprehensively capture a phenomenon; in this case, the strategies used by physicians to detect and manage culturally and gender-mediated presentations of psychosocial distress (Sandelowski, 2000). A comprehensive description is achieved by staying close to the data, while maintaining descriptive and interpretive validity (Sandelowski, 2000). Descriptive validity refers to the accurate description of the phenomenon (Sandelowski, 2000). In this study, minimal interpretation was used when describing the strategies and techniques utilized by the physicians. Interpretive validity refers to meaningfully situating phenomena according to participants' views and understandings (Sandelowski, 2000). This was achieved in the study by situating all findings within the clinical reality physicians described. This approach will also lend validity to the training module that will subsequently be developed in the later project, where these strategies will be consolidated and integrated into a training module complementary to the patient-centered method.

Study Setting

The study sample consisted of primary care physicians primarily practicing within the Côte-des-Neiges—Notre-Dame-de- Grâce borough of Montreal, Quebec. This is one of the most ethnoculturally and linguistically diverse neighbourhoods of Montreal; over half of the community identifies as a visible minority, 52% of the residents are immigrants, and 46% of the

community is allophone (Centraide of Greater Montréal, 2019; Corporation de développement communautaire de Côte-des-Neiges, 2017).

Study Sample & Recruitment Strategy

Reflecting the methodology, purposive snowball sampling was used to identify experienced primary care physicians recognized by their colleagues for their experience in intercultural clinical encounters concerning mental health. Purposive sampling was an appropriate strategy because it enables the identification of key, information-rich participants. Sampling aimed to achieve maximum variation in participants' gender and ethnocultural background. A total of 13 primary care providers participated in the study, with data saturation reached (no new themes) by the 9th interview. To be eligible, participants had to speak English or French; be a family medicine physician; and have a self-reported ethnoculturally diverse practice. Physicians that did not practice in a community-based family practice setting were excluded, as well as physicians that had not actively practiced in the last 5 years.

Methods

Data was collected through semi-structured in-depth interviews with family physicians. This method enabled the detailed exploration of topics, while providing some basis for comparison between participants (Green & Thorogood, 2018). The interviews were structured around several open-ended questions concerning how culture and gender influence the clinical encounter, presentations of psychosocial distress, and strategies used for the assessment of psychosocial distress. The semi-structured nature of the interviews presented the opportunity for participants to bring up pertinent topics that were not necessarily captured in the guide (Green & Thorogood, 2018). The family physician on the research team helped craft the interview

guidelines, ensuring clinical relevance. In addition, the interview guide was validated with an experienced family physician as well as a family medicine resident. The English and French interview guides are provided in appendices I and II, respectively.

Data Collection

All data was collected in English or French. The English interviews were audio-recorded and conducted by the graduate student, who has received training in qualitative research and methods. The French interviews were audio-recorded and conducted by the French research assistant. French interviews were initially transcribed in French and then translated to English, ensuring the integrity of the data was not lost in translation. All transcripts were anonymized, coded, and analyzed in English; however, quotes are presented in their original language. English translations of French quotes are provided in appendix III. Recruitment and data collection occurred concurrently with analysis until data saturation was reached – the point at which no new categories of expressions of psychosocial distress emerged, nor new strategies emerged (Miles et al., 2014). Reaching data saturation at 9 interviews is in line with similar work (Baik et al., 2005; Rosenberg et al., 2006).

Data Analysis

A thematic analysis began after the first few interviews were conducted, taking an iterative approach and guided by the Framework Method (Gale et al., 2013; Miles et al., 2014; Ritchie & Spencer, 1994). The Framework Method employs a flexible, yet systematic approach to organizing data through the creation of lower and higher order matrices (Gale et al., 2013; Miles et al., 2014; Ritchie & Spencer, 1994). The matrices facilitate comparisons and contrasts to be made across multiple respondents, as well as more conceptual explorations across broader

themes and constructs. Furthermore, the Framework Method accommodates both inductive and deductive analytic approaches (Gale et al., 2013; Miles et al., 2014; Ritchie & Spencer, 1994). Such flexibility was key in the study to accommodate "priori codes" from the patient-centered method as well as inductive codes that surfaced from the analysis process (Gale et al., 2013; Miles et al., 2014; Ritchie & Spencer, 1994).

The interviews ranged from 0.5-1.5 hours and were supplemented with post-interview analytic memos. The interviews were transcribed as soon as possible following their completion, supplemented with analytic memos. Prior to the initial coding of transcripts, familiarization processes (re-reading transcripts, re-listening to audio recordings, reviewing analytical memos) were employed. Based on this familiarization and "priori codes", an initial codebook was developed, spanning five primary categories. The codebook was iteratively developed with feedback from all members of the research team. The codebook was later transitioned to four primary categories; culture, gender, expressions, and assessment approach as the two prior codes were found to be redundant. Inter-coding reliability testing was completed between the graduate student and the research assistant. All conflicts were discussed and resolved by a third member of the research team when necessary.

Following, the transcripts were coded by the graduate student. Upon completing the initial coding of 4 interviews, an analytic framework was developed by grouping similar/related codes into categories that represent broader ideas (Gale et al., 2013; Miles et al., 2014; Ritchie & Spencer, 1994). The analytic framework was tested and then indexed to the remainder of the transcripts, with the flexibility to adjust for emerging codes (Gale et al., 2013; Miles et al., 2014; Ritchie & Spencer, 1994). The data was then charted into the data matrices – the characteristic feature of the Framework Method – to compare and contrast patterns and themes within and

across respondents, ensuring the data remained contextualized to the participant (Gale et al., 2013; Miles et al., 2014; Ritchie & Spencer, 1994). Detailed analytic memos accompanied all stages of analysis and contributed to the explanation of emerging patterns and themes. Regular meetings were held with the research team to discuss the coding process and emerging themes.

Data Management

Interviews were digitally recorded pursuant to respondent permission and supplemented by detailed field notes. Verbatim interview transcripts were prepared as soon as possible following the interview. English translations were created for French interviews. All participants were assigned a unique identifier and no nominative information was included in any of the field notes or embedded in any file names. The information linking identifiers and nominative information was stored on a double password-protected file. Dedoose software was used for data management and analysis.

Ethical Considerations & Confidentiality

Apart from the time required to participate, we did not anticipate any risks from participating in this study, nor was it anticipated that the research would inflict any harm. The physicians may have benefited from having the opportunity to reflect on and share the strategies and techniques they use in practice as this will help to improve the provision of care. This study obtained ethical approval from McGill University's internal review board. The ethics approval is provided in appendices IV and V.

Prior to obtaining consent, the graduate student emailed prospective participants a consent form entailing: a lay summary of the research project and its objectives, a description of the research team, funding sources, compensation, subject rights, risks and benefits, and

processes for confidentiality. The English and French consent forms are provided in appendices VI and VII, respectively. The consent form was explicit that participation in the research study was completely voluntary; that subjects had the right to not participate in the study, with no consequences or explanations needed; and that participants could have chosen not to answer any of the questions and or stop the interview at any point, with no consequences or explanations needed. Furthermore, participants could have withdrawn from the study at any point, with no consequences or explanations needed. Any potential risks and or benefits to participants from participating in the research were outlined. Participants were informed that all data collected would be anonymized and confidential, only available to the research team. All information was available in both English and French. Had participants wanted to verbally discuss any aspect of the research and or the consent process, the phone numbers of both an English and French member of the research team were provided. Verbal and signed consent were obtained upon meeting the participant for the interview.

RESULTS

This qualitative descriptive study explored the role of culture and gender-mediated factors on the detection and management of psychosocial distress in intercultural primary care encounters. Family physicians who are recognized by their colleagues as having expertise in the provision of intercultural mental health care were recruited. A total of 13 physicians completed the study; 9 interviews were conducted in English and 4 were conducted in French. The interview guide itself was structured around the patient-centered clinical method. Data saturation was reached by the 9th interview, with no new cues or strategies emerging in the French interviews. Many of the cues and strategies that physicians use in encounters are tacit rather than explicit. To elicit these strategies, physicians were probed to discuss specific cases. In general, it was easier for physicians to discuss the role of culture than gender. Consequently, gender was often explored in a very broad sense and clinical vignettes were used to help identify how gender influences physicians' approaches. Notably, gender was almost entirely discussed in a binary manner with a focus on general patterns in behaviours and expressions seen among women and men. While a universalist sentiment about how women and men behave and express themselves emerged in the discourse, this does not imply that physicians were unaware of deviations to the general patterns. It is possible the discourse remained at a general level due to the challenge of discussing these topics on the spot, without considerable time for reflection. It may also reflect the physicians' hesitancy in discussing whether or not their approach to care with women and men differ.

Overview of Themes

Three primary themes emerged relating to: 1) Cultural frames of mental health and expectations of care; 2) Assessment and management of expressions of psychosocial distress; and 3) Gendered roles and attitudes in mental health care. For the first two themes, several subsets of strategies were identified. For the gender theme, three patterns were identified. Although presented as discrete themes and strategies, they are intrinsically interwoven and as argued later, should be considered together in the design of a training module complementary to the patient-centered method.

Theme 1: Cultural Frames of Mental Health and Expectations of Care

All family physicians agreed that a patient's cultural background has an important role in shaping the clinical encounter. In particular, they noted how different understandings, norms, and stigmas of mental health are embedded within cultures, shaping how patients understand their illness and engage in the clinical encounter. Several physicians emphasized that mental health is not a shared concept in all cultures. What might be called depression or anxiety in Western biomedicine contexts may simply be understood as an emotion in other cultures, impacting the way emotional distress is described and expressed in the clinical encounter.

> *Dans beaucoup de cultures et dans plusieurs langues, le mot dépression n'existe pas. Donc j'ai déjà des interprètes qui m'ont dit le mot dépression, ça n'existe pas dans d'autres langues. Pourquoi ? Parce que tu n'as pas le droit d'être dans un mauvais état d'esprit mental. Ça ne fait pas partie de la culture… donc automatiquement, la seule façon de le manifester… [est] psychosomatique. (#9)*

Depending on previous healthcare experiences, such "emotions" may not be deemed an illness or pathology requiring medical attention. Physicians also noted that in certain cultures, it may be

taboo to discuss such emotions with individuals outside of the family due to collective values and different stigmatizations surrounding mental health. Expectations of care also differ across cultures. Physicians described how patients, whose prior healthcare experiences are from health systems based on curative models of care, often expect their clinical encounter to result in a prescription or follow-up investigations. These expectations impact how patients present and communicate their distress. Given these different frames, experiences, and expectations, patients may not explicitly bring forward their mental health concerns as they may not perceive it to be a concern, nor as something appropriate to discuss, impacting illness explanations, presentations, and potentially, appropriate treatment.

While recognizing the role of culture and gender in shaping mental health, physicians emphasized the importance of focusing on the individual, rather than specific culture or gender norms. Physicians felt uncomfortable making generalizations surrounding cultures and genders and preferred to talk at the individual case level. Nevertheless, general patterns among populations and genders were identified, along with deviations in such patterns. Physicians discussed the challenge of being aware of these different patterns, but not erroneously applying them to individual patients.

Strategies

Three strategies for balancing the need to understand cultural frames, while not losing sight of the individual were identified: 1) Explicitly asking patients about their culture; 2) Pleading ignorance to elicit illness narratives; and 3) Finding shared humanity.

1.1 Explicitly Asking Patients About Their Culture

In order to focus on the individual whilst being attuned to cultural factors, family physicians reported explicitly asking their patients about their culture and how they perceive it. In addition

to the insight this question provides on the patient's cultural background, physicians noted that it also presents an opportunity to build connection in instances of shared culture. Alternatively, if culture is not shared, physicians felt it helped convey that they see and recognize the differences at hand.

> *Well, I think it's important to be aware of specific cultural norms, but it is also important to see the individual within those cultural norms…So, I think there are certain similarities, but there's also the importance of seeing how they interpret their culture and their religion and their social status within their community. …And so it's important to be aware, but also to ask the person how do you identify? How do you see yourself within this community? Is this community important to you or are you hoping in Canada to be someone else, someone new? So, it's important to be like a bit of both. (#2)*

1.2 Pleading Ignorance to Elicit the Illness Narrative

To elicit the patient's narrative and gain a more holistic understanding of their patient, family physicians emphasized the importance of approaching encounters with a curious mindset. Physician #5 reported "pleading ignorance" as a strategy to help nudge patients to share their stories, while simultaneously empowering them. Similarly, physician 12 understood this as being a bit naïve.

> *Je [serai] naïf… Je pense que ça marche très souvent « Écoutez, regarde-moi, je ne connais pas ça. Vous m'expliquiez un peu. Comment ça fonctionne ? Comment ça se vit chez vous, comment c'est au pays ? » Ça dépend toujours. Mais souvent, ça se peut être une façon d'ouvrir le sujet qui n'est pas très menaçante. (#12)*

By asking patients to explain their beliefs, they often share about their family, home life, and lived experiences, all of which offer cues to possible underlying stressors in the patient's life. Physicians noted that these narratives often offer little pieces of information that stand out as not quite making sense. These are the pieces of information that are essential to explore further rather than brush off as they will often inform you as to *why* an individual is behaving and managing their health in a certain way. By identifying and understanding these cues, physicians can tailor their approaches to the patients' experiences.

> *If you don't ask "why?", [if] you don't ask "Why is this happen[ing]? Why do you think this is? Why? What do you understand about it?", then you're going to wander around in the universe doing 10,000 unnecessary investigations and not help anybody, right. It's all in the why. Tell me about it, tell me why, tell me what you think. (#6)*

1.3 Finding Shared Humanity

Key to being able to elicit and unravel this illness narrative is finding and developing shared humanity with the patient. Humanity is particularly important in the context of cultural differences as it enables a patient to feel as though the physician can understand them, strengthening the patient-doctor relationship. Physician #2 often connects over motherhood; physician #8 often connects over their military background with individuals in similar lines of work; physician #5 often connects over faith. Through this shared connection, patients often feel more comfortable disclosing their lived experiences, enabling their presentations to be appropriately situated within both individual and cultural frames.

> *"I think a lot of...my strategy is not to get this culture, get that culture, it's to find the commonality of who we are and just create trust… And I really think that that*

is a way of transcending a lot of issues with culture. So it's not understanding the culture itself and trying to like find the key, it's just finding the commonality amongst all cultures and focusing on that. (#5)

Theme 2: Assessment and Management of Expressions of Psychosocial Distress

Patterns in expressions and presentations of psychosocial distress were identified, often connected to various cultural frames and expectations of care. Family physicians emphasized that vague physical complaints are commonly presented initially, with further probing often elucidating an underlying mental health complaint. Common presentations include general musculoskeletal pain, fatigue, insomnia, and or headaches. Such presentations often serve as a cue to physicians that there may be a psychosocial component to the patient's illness. Symptoms that fail to align or point to an understandable condition may also indicate an underlying psychosocial issue. Additionally, the severity and duration of symptoms can further indicate a mental health challenge.

T'sais souvent ils vont nous dire qu'ils ont « pain all over the body » ou « headache » mais les mots pour moi qui me signalent une détresse, c'est quand il me parle d'intensité puis de durée. Donc « too much » puis « all the time » ... Ça pour moi, c'est toujours [ces] deux phrases qui sonnent une cloche de ok détresse psychologique à investiguer chez cette patiente-là, tout de suite. (#10)

These vague presentations were reported to be seen among patients from all cultural backgrounds and genders, but slightly more common among individuals from non-western cultures due to language barriers and different cultural frames of mental health. Physicians were hesitant to make any generalizations surrounding whether somatic presentations were more common among certain cultural groups and as such, refrained from identifying culture-specific

symptoms. Patterns of distress were more readily discerned among individuals with different frames of mental health and expectations of care.

> *People from other cultures don't always… have the same frame about what's going on, you know they often have a lot of different explanations, for why they're not feeling well, you know we see it one way, they have a totally different explanation of it. They often… come with like more somatic complaints, so a lot of like headache, back pain, tiredness, like they have other symptoms that we recognize here too, but I think, yeah, they might complain … a bit more about somatic issues, and if I, if you probe them a bit I mean it can become pretty obvious fast that it's more mental health issues but … I don't think that that's always how they see it. They really feel like there's something medically wrong. (#7)*

Due to these varying frames and experiences, physicians noted that different terms and expressions (cultural idioms) may be used to express illnesses. Common idioms included: listing multiple areas of pain, pain of large areas such as the whole back, the term "whole-body" pain, global manifestations of pain, and the use of the word tension as opposed to stress.

> *And it could be mild mental health problems, like the "too much pain", which obviously has been picked up around here. For us the joke is "whole-body pain". So it's not enough that you just have too much pain in your shoulder, now, to get medications, maybe an antibiotic, the best thing would be to identify numerous parts of pain; so the more painful areas, the more likely the doctor will give me an antibiotic. (#1)*

Strategies

Left with the clinical reality of these vague presentations, often suggestive of a psychosocial issue, yet not wanting to miss an underlying physical ailment, three prominent strategies were identified for the management of vague somatic presentations of distress: 1) Organic due diligence first; 2) Introducing practical aspects of well-being; and 3) Adopting appropriate authoritative strategies.

Although presented as sequential, these strategies are often employed together in synergistic ways. The time required to complete these physical tests provides an opportunity to gradually work in psychosocial aspects of well-being, while giving the physician the time to identify what cultural adaptations may be required to reach a common understanding of the patient's complaint and the appropriate management strategy. Continuity of care is foundational to this stepwise approach to assessment and reaching a shared understanding.

> *...Des fois le diagnostic se digère en plusieurs petits morceaux durant plusieurs rencontres que comprendre tout d'un coup la première fois. (#10)*

> *J'ai appris aussi que souvent, c'est d'y aller par étapes. C'est de ne pas lui dire « Écoutez, c'est de l'anxiété, de la dépression ». Il y a des gens pour qui c'est des mots qui n'existent même pas… ce n'est pas si simple que ça. (#12)*

2.1 Organic Due Diligence First

To assess varied presentations and expressions of psychosocial distress, family physicians tended to complete their "organic due diligence first" #(5), ruling out any potential underlying physical ailments as an initial diagnostic step.

But you have to do basic workup, you have to assure yourself, that you're not missing something, you know, the bad booboo. Right, and then you can just help, working people through and make the mind-body connection for them, gently. (#6)

Further investigation was deemed beneficial on several fronts. Firstly, it assures the physicians they are not missing anything. Secondly, patients often insist on additional testing as they can be adamant that there is a physical issue. Thirdly, providing a patient with a conclusive test result helps physicians nudge their patients toward the mental health component of their illness. In addition to clinically exploring patients' physical complaints, discussing these complaints often offers important insight into the patient's narrative.

…but I always include in my encounters, for any physical concerns, the concept of how this is making them feel, what is the impact on their function, ya know what they think is causing this, and so I think by systematically exploring those concerns and those perceptions of their symptoms, then often times that is the time where the mental health concerns do come out. (#2)

2.2 Introducing Practical Aspects of Well-being

After ruling out physical ailments, family physicians reported exploring psychosocial factors that could be contributing to the patient's distress. This was often done through a stepwise approach of legitimizing the patients' pain and experience, while helping them identify potential stressors in their life.

But then I'll see them back, with their results, and depending on the result…, if everything is normal then I can reassure them, ya know "all of this is normal", and I never say– I always say that "I know you're having this symptom and I see

that you have this symptom", but I also introduce the concept of how, for instance, mental health can impact pain and vice versa (#2)

Maintenant, c'est ça, quelqu'un qui est très résistant à l'idée qu'il s'apprête à parler de santé mentale, bin, c'est correct de partir de la plainte qui les dérange parce que c'est ça qui va les faire revenir… C'est ça qui va faire qu'on va pouvoir se parler, puis bâtir un peu sur cette confiance-là, de valider le symptôme, d'explorer le symptôme d'un point de vue médical, c'est ça que ça prend au départ pour les sécuriser, puis les amener à comprendre. Puis après ça, on va essayer de les faire cheminer dans le fait que ça se peut que des fois qu'il y a autre chose. (#12)

Identifying stressors was often done by probing on family, living situations, work, and social networks. Through the identification of stressors, physicians would then try to help patients make mind-body connections. To help bridge the mind-body connections, many physicians reported proposing strategies to improve general well-being, such as sleep and social connectedness. These strategies were particularly useful when patients were less accepting of mental health diagnoses. In general, practical discussions regarding well-being were perceived as more acceptable across cultures.

If their predominant symptom is a sleep problem, like if that's one of the symptoms of their depression is sleep, we might talk about like would you accept medication to help, that will try to improve your sleep? Often they'll accept that like, they'll understand that and it's like something very practical like if you help them sleep better, they're gonna have more energy and function better so often they're open to that and sometimes I'll describe more to them like we could treat

you with just something for sleep or we could give you something that might help you sleep and improve your mood. (#7)

In parallel, physicians described their efforts to orient patients to the scope of the healthcare system in Canada which embraces both mental and physical aspects, and to Western biomedical conceptualizations of mental health.

And in a lot of countries, the whole psychosocial aspect of medicine is completely outside of the physician's realm, so some of them at first don't quite understand what I'm doing right,…because a lot of patients will say "But I'm just feeling sad, but of course I'm feeling sad, look at what happened to me"…But there, yeah, there's a difference between being anxious in a proportion that is allowing you to still function, and now where you are, you're not unable to work, you're unable to sleep, you're, you know, you're functionally impaired by that anxiety, and in our medical world, there's a way we can help you with that if you want, so getting to that, like integrating psychiatric or psychological well-being into the health care perspective. (#5)

This included conveying to patients that certain levels of distress are recognized as diseases and that there are strategies and treatments to manage such distress. Explaining this helped build an understanding of the mind-body connection.

Cause I think with mental health, I think there is a perception that if we're saying that it's all just in your head, then it means that there's nothing to do, which is not the case. A mental health disorder is like any other health problem, we have treatment plans, we have approaches. And so it's important to share that there,

because I think it's a mental health problem it doesn't mean that we're not doing anything about it. On the contrary, we're doing a lot to address it. (#2)

2.3 Adopting Appropriate Authoritative Strategies

Across all family physicians interviewed, principles of family medicine, such as shared decision-making, were deemed essential to intercultural clinical encounters. However, many noted that in order to provide truly patient-centered care, incorporating more authoritative strategies into their approach is sometimes necessary. This reflects the fact that in various regions across the globe, more authoritative models of care are practiced, shaping patients' expectations of care. Consequently, patients do not always place the same value on shared-decision making, nor do they want to be asked "What do you think?".

I think in a lot of other cultures too like people don't really necessarily like to be asked like what they think it is, like they come to you because they expect a bit of a quick fix and a bit of, you to know what it is, so if you're telling them like "what do you think it is" and "what are you worried about" and "what would you want", they're not really too sure what the answer you–, they're like well I want to be better, but you have to tell me. So yeah, definitely I think like a lot of Western cultures like appreciate being involved in their care, but in another like culture sometimes it's not as appreciated. (#3)

However, adopting such authoritative strategies was viewed as going against the grain, sometimes creating a sense of tentativeness for physicians. Specifically, physicians grappled with finding a balance in their provision of care that accounts for the patients'

expectation of an authoritative doctor, but also reflects their professional value of shared decision making.

> *Je trouve que c'est plus difficile de, de faire en sorte que le patient partage spontanément ce qu'il pense ou ses attentes parce qu'il y a aussi une culture d'autorité qui est différente dans le sens que, t'sais souvent j'vais demander « oh mais qu'est-ce que tu penses qui cause ça » ou « qu'est-ce qui t'aiderais aujourd'hui ? » Puis j'vais souvent me faire répondre « je ne sais pas, vous, vous savez docteur. C'est vous le docteur » … ils vont vouloir que je prenne la décision par exemple. (#10)*

To adapt to this, physicians reported presenting patients with options and providing them space to make the decision for themselves, whilst also being more authoritative surrounding what choice will likely make them feel better. Often, physicians will share what *they* would do if they were in the patient's position. Most physicians were quite explicit that although it seems counterintuitive to embrace these more authoritative strategies, doing so is at the heart of patient-centered care.

> *I will be patient-centered recognizing that the patient is from a culture where the doctor decides, you know, and that, I mean, boy if you quote me on that now thunder and lightning is gonna come and strike me, but there are sometimes when people wanna be told what to do, right? So you say it in an open way in, "you know I don't wanna make it, I'm not I'm not here to make the decision for you, but you know I think that, yeah, antidepressants will be beneficial." (#5)*

Physician 5 highlights the professional, and possibly moral, dilemma of providing care that would typically be considered "outside" of Western medicine. However, they also

highlight how truly patient-centred care requires physicians to be able to adapt to differing frames and expectations of care.

> *...[I] try to help the patient come to a decision and ... offer them enough options so that they can see something that's gonna work for them and not impose too much on them. Tell them our experience and what we think is gonna make them better, but then try to figure out with them their own ideas and values about it, and then be okay to sit with that, even if it's not what we want them to do, what we think is in their best interest, that we just keep walking with this patient and keep, you know, having those conversations and keep offering opportunities for them to look at the, you know, to make decisions about their health that will be in their best interests. It's really hard sometimes as the physician to do that. (#7)*

Evidently, finding this nuanced balance in providing care may push physicians outside of their comfort zone. However, learning how to navigate such situations appears to be an implicit, yet crucial step in providing patient-centred care in intercultural encounters.

Theme 3: Gendered Roles and Attitudes in Mental Health Care

Across cultures, roles and responsibilities are ascribed to women and men based on cultural and societal values, among other factors. Through socialization processes, women and men also learn attitudes and behaviours that are deemed appropriate based on notions of femininity and masculinity. Although these two concepts are interconnected, their significance in shaping mental health care appears to differ by gender. Despite the difficulty or reluctance that family physicians had in identifying and articulating the role of gender, gender effects became evident in physicians' discussions surrounding: 1) Help-seeking behaviour and access to care; 2)

Expressions and presentations of distress; 3) Approaches to mental health care tailored by gender norms.

3.1 Help-Seeking Behaviour and Access to Care

Family physicians reported that women from all cultures generally tend to seek out and access care more than men. In the following quote by physician #1, a women's role as a caregiver is identified as a facilitator to care.

> *I'm expecting that if it's someone that identifies as a woman, then I think that certain things will be easier. My bias is that I'm assuming, that the women are allowed to come to medical services. Because they're looking after their kids, or they're looking after their parents, or they're pregnant, and so they're exposed to the medical field. They will, they will come. It's allowed to them to come and see a doctor. Whereas I find that for men, it might be a little bit more challenging because [there is this] machismo idea…the man is usually not sick and doesn't require help. (#1)*

Notably, although the caregiving role was perceived to be a facilitator to care by this physician, it was also often highlighted as a predominant stressor of mental health for women. Such gendered roles in facilitating care for men were not discussed, raising the question of whether men's gendered roles (e.g., financial provider) act as barriers to care. More prominent though, as evidenced by the quote above, may be the attitudinal barriers and stigma men experience in terms of accessing care and how it is often associated with weakness.

3.2 Expressions and Presentations of Distress

In terms of expressing and presenting distress, the family physicians perceived women to be more expressive (emotional) and open to discussing their mental health, whereas they perceived men to be less expressive and closed off. Many physicians noted that a patient's expressiveness is in part shaped by their own gender and that gender concordance helps facilitate discussion surrounding mental health.

> *Well, we know that men don't consult as much, like when it's needed, and I feel like sometimes they might try to kind of minimize cause they wanna look tough for stuff like that. So that can be a problem, definitely. I feel like women are more open generally to share like what they've been experiencing and things like that. So like in a way, it's easier with women, but it always depends on the person. Like men won't open up as much, they won't wanna detail as much how they've been feeling. (#4)*

This refractory attitude in men towards discussing mental health was raised by most physicians, noting it took more time to build the relationship with the men to a point where they might feel comfortable disclosing a challenge – particularly with female physicians. Similarly, many physicians noted that men often bring up concrete issues, such as work conflicts, to hint towards a mental health challenge. Probing on work was a strategy some physicians employed to initiate discussion on the topic.

3.3 Approaches to Mental Health Care Tailored by Gender Norms

The acceptance of mental health challenges was recognized as broadly shaped by culture, but more concretely by gender norms. Physicians noted that women generally tend to be more

accepting of mental health challenges. By contrast, men are generally perceived as less accepting of mental health challenges. Consequently, a patient's acceptance of mental health challenges has implications for how physicians' approach and develop care plans.

> *[Mental health acceptability] really depends on ya know both in terms of gender and in terms of culture… if they accept, like if it's acceptable to have ya know a mental health diagnosis, like if it's like culturally accepted… Like I think mental health is a little bit more accepted in women than in men. Same kind of thing, like ya know, kinda our dominant Western culture here is a little bit more acceptable than a lot of non-Western societies. (#3)*

> *I mean the cultures that I've worked with there's still a little stigma ya know for men to have mental health issues like depression is not like something that like ya know, just "suck it up buttercup" kind of thing. (#8)*

As evidenced in the quote below, the stigmatization of men's mental health and its association with weakness not only affects the patient's acceptance of mental health challenges, but also how the physician approaches the diagnosis. The physician may have a strong clinical suspicion of a mental health challenge underlying the physical presentation, but needs to work gently to also preserve the man's self-image of strength and capability to face the stressors of the immigrant experience.

> *Il y a une situation qui va se reproduire quand même souvent… je décèle que ce patient vient toujours me voir pour, des maux physiques mais moi, je pense en fait que c'est probablement de l'anxiété ou de la dépression ou un choc post-traumatique. Ça va être difficile d'ouvrir cette porte-là avec un homme parce que, pour eux, ça peut être parfois vu comme un signe de faiblesse. C'est beaucoup*

plus facile de revenir à la maison pour dire j'ai mal au dos… j'ai vraiment aucun intérêt à livrer de l'information qui va faire sentir le, un patient plus petit… Donc des fois, des fois on va traiter des maux physiques, même si on sait, même si on croit que le, le réel problème n'est pas vraiment physique. (#10)

The challenge of navigating gender dynamics for physicians may be further complicated during intercultural encounters as culture and gender power dynamics will interact. As highlighted in the quote below, physician #11 shares the challenge of being more assertive with men from a cultural background different than hers.

I feel much more comfortable talking to women. I feel that, with men from other cultures, sometimes I'm very resistant to making strong recommendations. Or as strong of recommendations because I'm, how would I put this…am I [less] comfortable sort of sharing my knowledge with them or do I feel like they have these cultural barriers that make it, less possible for them to accept what I have to say?... I guess I'm more worried about stepping on their toes. Like what are their cultural boundaries? Whereas with women, I feel a little bit more like I'm sharing my experience as a doctor, and I feel less like I'm going to offend them, if that makes any sense. So, I'm more comfortable really just speaking to them about what my recommendations are. (#11)

Evidently, the perceived stigmatization of men's mental health is a prominent barrier not only for patients, but also for physicians. In turn, this may impact how physicians approach the encounter and potentially may lead to under-detection and treatment of mental health challenges experienced by men.

It follows that gendered norms surrounding the acceptance of mental health impact the development of care plans. Family physicians noted that men tend to be more "give me the pills" (#5) for treatment, rather than discussing the underlying issue. Consequently, as noted by the following male physician, men are often more receptive to concrete, behaviour-level changes for treatment.

> *Je pense qu'il est encore aujourd'hui les monsieurs ont plus de difficultés à accepter qu'ils ont un trouble de santé mentale puis qu'une travailleuse sociale ou un psychologue, ça pourrait les aider. Ils sont peut-être plus intéressés quand je leur dis qu'il faut qu'il recommence à aller voir leurs chums, retourner à la shop, t'sais, à se forcer à retourner jouer au hockey. (#12)*

Women were thought to be more accepting of psychotherapy and in general more willing to discuss their challenges with friends. However, one physician noted that gendered roles can limit women's ability to spend time away from their homes, impeding their ability to establish their own networks and engage in behaviour-level changes, such as exercise classes. Notably, these roles of caregiving and household work are not inherently a woman's role but are ascribed to women in many cultures.

> *So, for a lot of patients, one of the first steps is exploring the network, and how you can connect back into your network, and how you can be more activated in society. Well for these women it's really difficult because it has to be a place where they understand the language, it has to be a place where they're able to bring along their young children. And so it's very difficult to find places for them to build that network. (#2)*

For both men and women, physicians emphasized that there is a general lack of mental health services available, especially ones that are culturally tailored. Consequently, community and religious organizations often fill this gap and are leveraged into care plans.

DISCUSSION

This qualitative descriptive study found that family physicians recognized by peers as having expertise in the detection and management of psychosocial distress in intercultural primary care encounters have developed tacit knowledge and implicit strategies to detect and manage expressions of psychosocial distress. Though careful to avoid cultural stereotyping, expert family physicians recognized that a patient's cultural background frames understandings and expressions of mental health and have developed approaches in intercultural clinical encounters to render visible the cultural frame to both the physician and the patient. They have learned that vague physical complaints and "odd" expressions of pain could signal psychosocial distress, but diligently took the time to rule out physical causes and gradually bring into the patient's awareness the impact of mental health stressors on health and well-being. Though apparently reluctant to make assumptions about the role of gender in the clinical encounter, they alluded to gender-mediated differences in help-seeking behaviour and patients' willingness to express mental health challenges and took gender roles into consideration in making care plans. Although presented as discrete themes and strategies, they are intrinsically interwoven and are coherent with the practice of the patient-centered method, as discussed below.

Approaches to Intercultural Encounters

The intercultural expertise of the family physicians in the study resides not in acknowledging that culture is an important factor in the clinical encounter, but in the recognition that the influence of the patient's culture frame varies between individuals and depends on the medical need. These physicians were careful not to assume what patients wanted; rather, physicians reported making conscious efforts to ask patients what they wanted and how they made sense of their culture. Instead of using stereotypes to generate hypotheses surrounding

diagnoses and treatment expectations, stereotypes or generalizations were used to inform questioning aimed at understanding their patient within a larger social-cultural frame. They employ strategies to create space for exploring the influence of sociocultural factors by pleading ignorance about the patient's culture and explicitly asking questions to elicit narratives. They establish common ground by finding shared humanity. These patient-centered strategies echo those found by other studies of intercultural clinical strategies.

In a study conducted by Rosenberg and colleagues (2007) on general practitioners' strategies used in intercultural encounters, the following strategies were reported: 1) insistence on patient adaptation to local beliefs and behaviours; 2) physician adaptation to what he or she assumed patients wanted; and 3) negotiation of a mutually acceptable plan. Participants in this study reported that they used the patient-centered method to guide their approach, however, they lacked a framework for eliciting culturally specific information. Our findings help to fill this gap by providing a general approach and pragmatic strategies for eliciting this information. In a different study by Rosenberg and colleagues (2006) focused on intercultural communication between physicians and immigrant patients, four strategies were found when physicians chose to address the cross-cultural nature of the encounter: a) taking time to understand and recognize cultural barriers in terms of health beliefs; b) manifesting interest in lifestyles in other countries; asking question about a patient's country of origin; c) being mindful of therapeutic interventions that may not be culturally appropriate; and d) developing methods of establishing a relationship with new patients based on previous encounters with patients from the same cultural background. A study by Baik and colleagues (2005) on the recognition of depression in primary care reported three strategies used by physicians: 1) ruling out; 2) opening the door; and 3) recognizing the person. The strategies employed depended on the physicians' relationship with the patient, their

clinical experience, and time restraints (Baik et al., 2005). Our findings are complementary to these studies, providing more explicit strategies that follow the patient-centered method.

Expressions and Presentations of Psychosocial Distress

Going past the mere detection of psychosocial distress, the family physicians in our study have developed strategies for situating and managing varied expressions and presentations of distress. Though these cases are recognized as challenging, physicians reported that they seldom escalate cases to transcultural psychiatry. Instead, through a curious approach, physicians explore and situate these expressions of distress at the primary care level by eliciting illness narratives to understand cultural context and assess and manage these expressions through organic due diligence and the gradual introduction of steps for general well-being. These findings form a flexible approach to exploring, situating, and managing expressions of distress in primary care settings, complementary to both the patient-centered method and approaches in cultural psychiatry.

In the field of cultural psychiatry, there has been extensive research on cultural experiences, understandings, and expressions of distress (Kohrt et al., 2014). To better understand and capture cultural variations in distress, the Diagnostic and Statistical Manual of Mental Disorders (DSM) introduced the category "Cultural Concepts of Distress" in the fifth edition (Kohrt et al., 2014; Lewis-Fernández & Kirmayer, 2019). The different types of cultural concepts of distress include cultural idioms of distress, cultural syndromes, and cultural explanations (Lewis-Fernández & Kirmayer, 2019). Cultural concepts of distress differ from psychiatric disorders in that they do not necessarily have a clinical syndrome and their associated level of distress can vary greatly, among other factors (Lewis-Fernández & Kirmayer, 2019). As such, Lewis-Fernández and Kirmayer (2019) argue that some cultural concepts of distress "can

be utilized as idioms, that is, as a means of communicating information in social relationships. As such, they must be understood in relation to the social communicative context in which they arise and to which they are directed." (p. 788).

Evidently, cultural concepts of distress exist on a continuum and family physicians are well positioned to identify and manage the "milder" cultural concepts of distress, given the proper training. This may include increasing residents' and physicians' awareness to various cultural idioms of distress while also learning how to explore and situate them. Such training may be particularly beneficial for residents and physicians who work with immigrant, refugee, and asylum-seeking populations as subpopulations of migrants are subject to a higher prevalence of mental health disorders, especially those that are stress-related (Rousseau & Frounfelker, 2019). Often this distress presents through pain and fatigue (Rousseau & Frounfelker, 2019). In cultural psychiatry, there has been attention paid to the role of cultural concepts of distress as indicators of vulnerable populations who may benefit from psychosocial interventions (Kohrt et al., 2014). This coincides with our findings, where the most distinct presentations of psychosocial distress were reported among refugees and asylum seekers, often with precarious legal situations and uncertainties in their hearing process. For these populations, the family physicians in our study reported that it is very common for patients to present with extreme mental anguish and somatic complaints. The frequency and severity of the distress appear to correlate with patients' hearing processes; as hearing dates approach so do levels of distress and service use. Upon a successful hearing, the distress will almost instantly resolve. Thus, as expressed by participants, there lies a challenge in properly investigating these complaints, but also not medicalizing a problem that is really due to migratory stressors. Given increasing rates of migration to Canada, improving physicians' and residents' capacity to provide care to these

populations is essential (Statistics Canada, 2022). Future research may explore more explicitly the expressions and presentation of psychosocial stress among these sub-populations of migrants in primary care, as much of the work has been done at the tertiary level. Such work has the potential to prevent the under detection, misdiagnosis, and over-investigation of psychosocial distress in primary care and improve the quality of care provided.

The Role of Gender in the Clinical Encounter

Family physicians appear to approach gender paradoxically in the clinical encounter. On the one hand, family physicians are aware of differences between women and men in terms of help-seeking behaviour and openness to discussing mental health problems; yet at the same time, they are hesitant to suggest that gender may alter their approach in the encounter. Interestingly, the physicians were much more aware and comfortable talking about differences between cultures and the need to culturally tailor their approaches at times. However, with gender, it appears that there is an underlying sentiment that women and men should not be treated differently. This in part may reflect that physicians take comprehensive assessment approaches that do not explicitly focus on gender, such that the strategies employed for exploring culture would also apply to gender, as to other social and personal factors. However, it also likely reflects the hidden role of gender in clinical encounters. Consequently, the patterns of how internalized gender norms and roles are perceived to impact the expression and presentation of distress, along with how physicians detect and manage metal health emerged as patterns implicitly rather than as explicitly-deployed strategies.

Evidently, gender-related mental health stigmas and biases held by both the patient and physician shape the clinical encounter. To account for this, gender-sensitive training programs may be implemented. Although the development and evaluation of such training programs are

still relatively novel, research has found significant differences in knowledge, attitudes, and behaviours after completing different training modules (Lindsay et al., 2019).

LIMITATIONS

This study explored how culture and gender impact the expression and detection of mental health challenges in primary care encounters. However, culture and gender are not the sole factors at play in an encounter, nor the most relevant at times. Given the intertwined intricacy of language, culture, and ethnicity, along with other social determinants of mental health, there was likely conflation between these factors during participant interviews. Similarly, due to the population served by our sample of physicians, there may have been conflation with immigration, residency processes, and acculturation. These factors reflect the complexity of intercultural encounters and the challenge of attending to multiple dynamics that span medical, culture, gender, and social needs. It is also important to note that some of the conflations or overgeneralizations may be attributed to the inherent challenge of reflecting on these topics on the spot. Consequently, physicians' responses may not have been as nuanced as they would have been if the physicians prepared for the interview ahead of time.

The findings of this study are subject to social desirability bias. This is particularly true for the discussions of culture and gender, given society's increasing attention to issues of equity, diversity, and inclusion, and may account for the reticence to acknowledge gender-based strategies. However, the interviewer's efforts to create a judgement-free atmosphere and the implicit power dynamic between the graduate student and the physicians interviewed was favourable towards the physicians' expertise, enabling them to openly discuss these topics. There is a chance that physicians reported strategies that they do not actually utilize, though that seems unlikely given that their expertise was acknowledged by several peers. Additionally, some of the cues and strategies used by physicians may have been missed as it can be difficult to reflect on

tacit knowledge. To comprehensively capture the strategies used by physicians, a more in-depth ethnographic study would allow these strategies to be observed in real clinical encounters.

Lastly, the results from this study are from a sample of physicians practicing mainly within the Côte-des-Neiges–Notre-Dame-de-Grâce area of Montréal. Consequently, there is considerable overlap in the populations they serve, the cases that present, and what strategies might work for these populations. Therefore, the findings from this study may not be generalizable to other settings. Nevertheless, the findings represent a useful first step in establishing patient-centered strategies for intercultural encounters in a context of increasing immigration and diversity within Canada. Future research and evaluation will be useful in further adapting the strategies to a broader range of cultures and in developing physicians' sensitivities to different dynamics at play in intercultural encounters.

IMPLICATIONS FOR PRACTICE

Addressing Social Needs in Family Practice

Although the explicit implications of social and economic factors were not thoroughly discussed with physicians in our study, almost all participants raised their pertinence. These discussions often pertained to the underlying sources of their patients' distress, recognizing the salience of the social determinants of health. For example, physicians often discussed immigration stressors or having enough money to buy groceries at the end of the month with their patients. Although it can be argued that these social issues are manifestations of larger structural forces, they still have implications for the clinical reality. Thus, attention is needed at both levels, rather than dichotomizing the problem.

In addition to standard referrals to social workers and community groups, one promising approach to address patients' social needs in family practice is through social prescription. Social prescription is a model and an approach to care that aims to address patients' unmet social needs and goals by connecting them to non-clinical services in the community (Bloch & Rozmovits, 2021; Nowak & Mulligan, 2021). Research indicates that social prescribing not only improves patients' mental and physical well-being, but it also supports team-based approaches to care and may help alleviate the demand on general practitioners and emergency departments (Alliance for Healthier Communities, 2020; Polley & Pilkington, 2017). However, as noted by physicians in our study, addressing social needs is often limited by the lack of services available. Even with the limited services available, physicians noted that their patients often face barriers to accessing them due to financial constraints, language barriers, and childcare, among others. Thus, for the effective implementation of such models in practice, training, support, and buy-in from the health, community, and political sectors are essential.

At the clinical level, training may be provided on structural competency during undergraduate training and in continuing education. Structural competency focuses on addressing social, economic, cultural, and political factors that underly inequities in access to healthcare and health outcomes (Metzl & Hansen, 2014). The emphasis on *structural* social factors is the defining feature that distinguishes this model from the cultural competency model, which is situated more at the *physician/institution* level (Metzl & Hansen, 2014). However, it has been argued that such structural social factors are mediated by cultural meaning and values and that by focusing on structural determinants, the highly personal impacts of the determinants are diminished (Kirmayer & Jarvis, 2019). Nevertheless, it is evident that further attention to the social structural causes of health inequities and their sociocultural implications warrants further attention in family medicine.

Implications for Clinical Training of Family Physicians

The findings from this qualitative study will be used to inform an intercultural training module for family medicine residents. Despite the increasingly diverse ethnocultural makeup of the Canadian population, especially in urban settings, guidance on how to recognize the disease experience of culturally diverse patients is lacking (Gustafson & Reitmanova, 2010; Singh et al., 2017). During training, scant attention is given to ethnocultural expressions of mental health, representing a missed opportunity to give primary care clinicians pragmatic strategies for accurately detecting and treating psychosocial distress in the context of intercultural encounters (Rosenberg et al., 2007). Canadian family medicine residents themselves report needing more training on this topic (Singh et al., 2017). In a workshop series on "Inclusive Care" at the St. Mary's family medicine teaching unit, culturally competent mental health care was mentioned by

the residents as one of their main challenges in providing appropriate care to the population they serve (Personal communication, I. Leblanc).

Consequently, the plan is to integrate the ethnocultural strategies found in this study into a module that will build on the knowledge acquired in undergraduate medical training, pertaining to patient-centered communication. Though the patient-centred clinical method is widely invoked during family medicine residency training as a communication approach for exploring and contextualizing the presentation of illness and disease, the method is taught predominantly through the apprenticeship model, and not through a formal training module. A formal module will not only consolidate the patient-centered communication skills, but integrating pragmatic strategies found in this study will expand the exposure of family medicine residents to family physicians with a recognized expertise in intercultural encounters. This will more consistently build patient-centered and culturally-responsive approaches to mental health care for diverse populations.

An element to integrate in the module design is building physicians' awareness of how their own culture and gender shape the power dynamics of the intercultural encounter. When specifically asked about this, some physicians felt their backgrounds did not shape the encounter as they took an objective approach. Others noted the role of their gender in facilitating or hindering conversations. Some noted that shared ethnocultural backgrounds help build connections. However, physicians rarely problematized the role of their culture and gender in terms of power dynamics and biases. As emphasized in the literature, explicit attention to power dynamics is necessary (Brascoupé & Waters, 2009; Emslie et al., 2007).

The training module will eventually be developed in both English and French, but will initially be developed and delivered in English at St. Mary's training clinic during an academic

half-day. Interpreters and patients will be consulted during the development of the module as well. Based on feedback from beta testing, the hope is to obtain funding to adapt the module to a larger population of family medicine residents across Quebec and Canada. The module will include intercultural items from the validated 27-item instrument of self-efficacy in patient-centered communication (SEPCQ-27) developed by Zachariae and colleagues (2015), to evaluate the impact of the module on residency self-efficacy and willingness to care for ethnoculturally diverse populations in the future.

CONCLUSION

This qualitative descriptive study of strategies used by 'expert' family physicians to detect and manage mental health challenges in intercultural primary care encounters found culture and gender play an important role in shaping the expression and detection of psychosocial distress. Although general patterns in the expression and presentation of psychosocial distress exist, physicians stress the importance of focusing on the individual within these broader cultural frames. Physicians employ several strategies to collaboratively explore and situate patients' illnesses, while performing complementary physical investigations. Continuity of care is fundamental to establish the necessary trust and time for such comprehensive care. The intertwined intricacy of language, culture, ethnicity, and gender, along with other social determinants of mental health demonstrate the complexity of intercultural encounters and the challenge of attending to medical, cultural, gender, and social considerations in managing psychological distress. Nonetheless, the analysis identified pragmatic and reproducible strategies that can be taught to other physicians.

REFERENCES

Afifi, M. (2007). Gender differences in mental health. *Singapore Medical Journal*, *48*, 385–391.

Allemang, B., Sitter, K., & Dimitropoulos, G. (2022). Pragmatism as a paradigm for patient-oriented research. *Health Expectations*, *25*(1), 38–47. https://doi.org/10.1111/hex.13384

Alliance for Healthier Communities. (2020). *Rx: Community—Social Prescriping in Ontario, Final Report.* Alliance for Healthier Communities. https://cdn.ymaws.com/aohc.site-ym.com/resource/group/e0802d2e-298a-4d86-8af5-21156f9c057f/rxcommunity_final_report_mar.pdf

Andermann, L. (2010). Culture and the social construction of gender: Mapping the intersection with mental health. *International Review of Psychiatry*, *22*(5), 501–512. https://doi.org/10.3109/09540261.2010.506184

Aragona, M., Tarsitani, L., Colosimo, F., Martinelli, B., Raad, H., Maisano, B., & Geraci, S. (2005). Somatization in Primary Care: A Comparative Survey of Immigrants from Various Ethnic Groups in Rome, Italy. *The International Journal of Psychiatry in Medicine*, *35*(3), 241–248. https://doi.org/10.2190/2G8N-MNNE-PGGP-PJJQ

Baik, S.-Y., Bowers, B. J., Oakley, L. D., & Susman, J. L. (2005). The recognition of depression: The primary care clinician's perspective. *Annals of Family Medicine*, *3*(1), 31–37. https://doi.org/10.1370/afm.239

Bhatt, A., Tomenson, B., & Benjamin, S. (1989). Transcultural patterns of somatization in primary care: A preliminary report. *Journal of Psychosomatic Research*, *33*(6), 671–680. https://doi.org/10.1016/0022-3999(89)90082-2

Bloch, G., & Rozmovits, L. (2021). Implementing social interventions in primary care. *CMAJ*, *193*(44), E1696–E1701. https://doi.org/10.1503/cmaj.210229

Bragazzi, N. L., Puente, G. D., & Natta, W. M. (2014). Somatic perception, cultural differences and immigration: results from administration of the Modified Somatic Perception Questionnaire (MSPQ) to a sample of immigrants. Psychology research and behavior management, 7, 161–166. https://doi.org/10.2147/PRBM.S55393

Brascoupé, S., & Waters, C. (2009). Cultural safety exploring the applicability of the concept of cultural safety to aboriginal health and community wellness. *International Journal of Indigenous Health*, *5*(2). https://jps.library.utoronto.ca/index.php/ijih/article/view/28981

Bridges, K., & Goldberg, D. (1987). Somatic presentation of depressive illness in primary care. *The Journal of the Royal College of General Practitioners. Occasional Paper*, *36*, 9–11. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2573691/

Brownhill, S., Wilhelm, K., Barclay, L., & Schmied, V. (2005). 'Big Build': Hidden Depression in Men. *Australian & New Zealand Journal of Psychiatry*, *39*(10), 921–931. https://doi.org/10.1080/j.1440-1614.2005.01665.x

Brownhill, S., Wilhelm, K., Eliovson, G., & Waterhouse, M. (2003). "For men only". A mental health prompt list in primary care. *Australian Family Physician*, *32*(6), 443–450.

Centraide of Greater Montréal. (2019). *Territorial-profiles-Montreal-Cote-des-Neiges-2018-2019.pdf*. https://www.centraide-mtl.org/wp-content/uploads/2021/01/Territorial-profiles-Montreal-Cote-des-Neiges-2018-2019.pdf

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic differences in mental health status and service utilization: A population-based study in Ontario, Canada. *The Canadian Journal of Psychiatry*, *63*(7), 481–491. https://doi.org/10.1177/0706743717741061

Clatney, L., MacDonald, H., & Shah, S. M. (2008). Mental health care in the primary care setting: Family physicians' perspectives. *Canadian Family Physician*, *54*(6), 884–889. https://www.cfp.ca/content/54/6/884

Corporation de développement communautaire de Côte-des-Neiges. (2017). *Portrait-Côte-des-Neiges-2017-English.pdf*. http://www.conseilcdn.qc.ca/wordpress/wp-content/uploads/2017/03/Portrait-C%C3%B4te-des-Neiges-2017-English.pdf

Cross, W. M., & Bloomer, M. J. (2010). Extending boundaries: Clinical communication with culturally and linguistically diverse mental health clients and carers. *International Journal of Mental Health Nursing*, *19*(4), 268–277. https://doi.org/10.1111/j.1447-0349.2010.00667.x

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Danielsson, U., & Johansson, E. (2005). Beyond weeping and crying: A gender analysis of expressions of depression. *Scandinavian Journal of Primary Health Care, 23*(3), 171–177. https://doi.org/10.1080/02813430510031315

De Maesschalck, S., Deveugele, M., & Willems, S. (2011). Language, culture and emotions: Exploring ethnic minority patients' emotional expressions in primary healthcare consultations. *Patient Education and Counseling*, *84*(3), 406–412. https://doi.org/10.1016/j.pec.2011.04.021

Denton, M., Prus, S., & Walters, V. (2004). Gender differences in health: A Canadian study of the psychosocial, structural and behavioural determinants of health. *Social Science & Medicine (1982)*, *58*(12), 2585–2600. https://doi.org/10.1016/j.socscimed.2003.09.008

Dune, T., Caputi, P., & Walker, B. (2018). A systematic review of mental health care workers' constructions about culturally and linguistically diverse people. *PloS One*, *13*(7), e0200662. https://doi.org/10.1371/journal.pone.0200662

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2007). Exploring men's and women's experiences of depression and engagement with health professionals: More similarities than differences? A qualitative interview study. *BMC Family Practice*, *8*(1), 43. https://doi.org/10.1186/1471-2296-8-43

Fleury, M.-J., Farand, L., Aubé, D., & Imboua, A. (2012). Management of mental health problems by general practitioners in Quebec. *Canadian Family Physician Medecin De Famille Canadien*, *58*(12), e732-738, e725-731.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, *13*, 117. https://doi.org/10.1186/1471-2288-13-117

Garcia, M. E., Hinton, L., Gregorich, S. E., Livaudais-Toman, J., Kaplan, C., & Karliner, L. (2020). Unmet mental health need among Chinese and Latino primary care patients: Intersection of ethnicity, gender, and English proficiency. *Journal of General Internal Medicine*, *35*(4), 1245–1251. https://doi.org/10.1007/s11606-019-05483-9

García-Sierra, R., Fernández-Cano, M. I., Manresa-Domínguez, J. M., Feijoo-Cid, M., Moreno Gabriel, E., Arreciado Marañón, A., Ramos-Roure, F., Segura-Bernal, J., & Torán-Monserrat, P. (2020). Psychological distress and somatization in immigrants in primary

health care practices. *Healthcare (Basel, Switzerland)*, *8*(4). https://doi.org/10.3390/healthcare8040557

Gonzales, H. (2018). Somatisation in primary care: A comparative study of Australians, Aatin Americans, Vietnamese, and Polish living in Australia. *Psycherg Journal of Psychology*, *1*(2), 39–55. https://doi.org/10.5281/ZENODO.1256920

Gopalkrishnan, N. (2018). Cultural diversity and mental health: Considerations for policy and practice. *Frontiers in Public Health*, *6*. https://doi.org/10.3389/fpubh.2018.00179

Green, J., & Thorogood, N. (2018). Qualitative Methods for Health Research. In *Qualitative Methods for Health Research* (4th ed.). SAGE Publications. https://us.sagepub.com/en-us/nam/qualitative-methods-for-health-research/book254905

Gureje, O., Simon, G. E., Ustun, T. B., & Goldberg, D. P. (1997). Somatization in cross-cultural perspective: A World Health Organization study in primary care. *Journal of Psychiatry*, *154*(7), 989–995.

Islam, F., Khanlou, N., Macpherson, A., & Tamim, H. (2018). Mental health consultation among Ontario's immigrant populations. *Community Mental Health Journal*, *54*(5), 579–589. https://doi.org/10.1007/s10597-017-0210-z

Johnson, J. L., Greaves, L., & Repta, R. (2009). Better science with sex and gender: Facilitating the use of a sex and gender-based analysis in health research. *International Journal for Equity in Health*, *8*(1), 14. https://doi.org/10.1186/1475-9276-8-14

Kaushik, V., & Walsh, C. A. (2019). Pragmatism as a research paradigm and its implications for social work research. *Social Sciences*, *8*(9). https://doi.org/10.3390/socsci8090255

Kerr, L. K., & Kerr, L. D. (2001). Screening tools for depression in primary care. *Western Journal of Medicine*, *175*(5), 349–352. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071624/

Khoo, E. M., Mathers, N. J., McCarthy, S. A., & Low, W. Y. (2012). Somatisation disorder and its associated factors in multiethnic primary care clinic attenders. *International Journal of Behavioral Medicine*, *19*(2), 165–173. https://doi.org/10.1007/s12529-011-9164-7

Kirmayer, L. (2001). Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. *The Journal of clinical psychiatry*, *62 Suppl 13*, 22–30.

Kirmayer, L. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L., & Minas, H. (2000). The future of cultural psychiatry: An international perspective. *The Canadian Journal of Psychiatry*, *45*(5), 438–446. https://doi.org/10.1177/070674370004500503

Kirmayer, L., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ : Canadian Medical Association Journal*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kirmayer, L, & Robbins, J. (1996). Patients who somatize in primary care: A longitudinal study of cognitive and social characteristics. *Psychological Medicine*, *26*(5), 937–951. https://doi.org/10.1017/s0033291700035273

Kirmayer, L., & Jarvis, G. (2019). Culturally responsive services as a path to equity in mental healthcare. *HealthcarePapers*, *18*(2), 11–23. https://doi.org/10.12927/hcpap.2019.25925

Kiropoulos, L. A., Blashki, G., & Klimidis, S. (2005). Managing mental illness in patients from CALD backgrounds. *Australian Family Physician*, *34*(4), 259–264.

Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. *PLOS Medicine*, *3*(10), e294. https://doi.org/10.1371/journal.pmed.0030294

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, *88*, 251–258. https://doi.org/10.1176/foc.4.1.140

Kohrt, B. A., Rasmussen, A., Kaiser, B. N., Haroz, E. E., Maharjan, S. M., Mutamba, B. B., de Jong, J. T., & Hinton, D. E. (2014). Cultural concepts of distress and psychiatric disorders: Literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology*, *43*(2), 365–406. https://doi.org/10.1093/ije/dyt227

Lehti, A. H., Johansson, E. E., Bengs, C., Danielsson, U., & Hammarström, A. (2010). "The Western Gaze"—An analysis of medical research publications concerning the expressions of depression, focusing on ethnicity and gender. *Health Care for Women International*, *31*(2), 100–112. https://doi.org/10.1080/07399330903067861

Lewis-Fernández, R., & Kirmayer, L. J. (2019). Cultural concepts of distress and psychiatric disorders: Understanding symptom experience and expression in context. *Transcultural Psychiatry*, *56*(4), 786–803. https://doi.org/10.1177/1363461519861795

Lindsay, S., & Kolne, K. (2020). Understanding clinicians' strategies for providing gender-sensitive care: An exploration among pediatric rehabilitation health care providers.

Disability and Rehabilitation, *0*(0), 1–11. https://doi.org/10.1080/09638288.2020.1836270

Lindsay, S., Rezai, M., Kolne, K., & Osten, V. (2019). Outcomes of gender-sensitivity educational interventions for healthcare providers: A systematic review. *Health Education Journal*, *78*(8), 958–976. https://doi.org/10.1177/0017896919859908

Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K., & Payne, S. (2001). Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *BMJ : British Medical Journal*, *323*(7318), 908–911. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC58543/

Lowe, B., Spitzer, R. L., Williams, J. B. W., Mussell, M., Schellberg, D., & Kroenke, K. (2008). Depression, anxiety and somatization in primary care: Syndrome overlap and functional impairment. *General Hospital Psychiatry*, *30*(3), 191–199. https://doi.org/10.1016/j.genhosppsych.2008.01.001

Mallinson, S., & Popay, J. (2007). Describing depression: Ethnicity and the use of somatic imagery in accounts of mental distress. *Sociology of Health & Illness*, *29*(6), 857–871. https://doi.org/10.1111/j.1467-9566.2007.01048.x

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine (1982)*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Miers, M. (2002). Developing an understanding of gender sensitive care: Exploring concepts and knowledge. *Journal of Advanced Nursing*, *40*(1), 69–77. https://doi.org/10.1046/j.1365-2648.2002.02341.x

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). Qualitative Data Analysis: A Methods Sourcebook. Third Edition. In *SAGE Publications Ltd (CA)*. SAGE Publications.

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*, *33*(6), 282–287. https://doi.org/10.1177/0840470420933911

Nixon, S. A. (2019). The coin model of privilege and critical allyship: Implications for health. *BMC Public Health*, *19*(1), 1637. https://doi.org/10.1186/s12889-019-7884-9

Nowak, D. A., & Mulligan, K. (2021). Social prescribing: A call to action. *Canadian Family Physician*, *67*(2), 88–91. https://doi.org/10.46747/cfp.670288

Patel, V. (2001). Cultural factors and international epidemiology. *British Medical Bulletin*, *57*, 33–45. https://doi.org/10.1093/bmb/57.1.33

Polley, M. J., & Pilkington, K. (2017, June). *A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications* [Technical report]. University of Westminster. https://www.westminster.ac.uk/file/107671/download

Public Health Agency of Canada. (2018). *Key health inequalities in Canada: A national portrait : executive summary.* http://epe.lac-bac.gc.ca/100/201/301/weekly_acquisitions_list-ef/2018/18-48/publications.gc.ca/collections/collection_2018/aspc-phac/HP35-109-1-2018-eng-1.pdf

Rice, S. M., Oliffe, J. L., Kealy, D., Seidler, Z. E., & Ogrodniczuk, J. S. (2020). Men's help-seeking for depression: Attitudinal and structural barriers in symptomatic men. *Journal of Primary Care & Community Health*, *11*, 2150132720921686. https://doi.org/10.1177/2150132720921686

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In *Analyzing Qualitative Data*. Routledge.

Rosenberg, E., Kirmayer, L. J., Xenocostas, S., Dao, M. D., & Loignon, C. (2007). GPs' strategies in intercultural clinical encounters. *Family Practice*, *24*(2), 145–151. https://doi.org/10.1093/fampra/cmm004

Rosenberg, E., Richard, C., Lussier, M.-T., & Abdool, S. N. (2006). Intercultural communication competence in family medicine: Lessons from the field. *Patient Education and Counseling*, *61*(2), 236–245. https://doi.org/10.1016/j.pec.2005.04.002

Rousseau, C., & Frounfelker, R. L. (2019). Mental health needs and services for migrants: An overview for primary care providers. *Journal of Travel Medicine*, *26*(2). https://doi.org/10.1093/jtm/tay150

Ryder, A., Yang, J., & Heine, S. (2002). Somatization vs. psychologization of emotional distress: A paradigmatic example for cultural psychopathology. *Online Readings in Psychology and Culture*, *10*(2). https://doi.org/10.9707/2307-0919.1080

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Seidler, Z. E., Rice, S. M., Dhillon, H. M., & Herrman, H. (2019). Why it's time to focus on masculinity in mental health training and clinical practice. *Australasian Psychiatry*, *27*(2), 157–159. https://doi.org/10.1177/1039856218804340

Seidler, Z. E., Rice, S. M., Ogrodniczuk, J. S., Oliffe, J. L., Shaw, J. M., & Dhillon, H. M. (2019). Men, masculinities, depression: Implications for mental health services from a

Delphi expert consensus study. *Professional Psychology: Research and Practice*, *50*(1), 51–61. https://doi.org/10.1037/pro0000220

Sheikh, S., & Furnham, A. (2012). The relationship between somatic expression, psychological distress and GP consultation in two cultural groups. *Counselling Psychology Quarterly*, *25*(4), 389–402. https://doi.org/10.1080/09515070.2012.735860

Simon, G., Gater, R., Kisely, S., & Piccinelli, M. (1996). Somatic symptoms of distress: An international primary care study. *Psychosomatic medicine*, *58*(5), 481–488. https://doi.org/10.1097/00006842-199609000-00010

Sleath, B., & Rubin, R. H. (2002). Gender, ethnicity, and physician–patient communication about depression and anxiety in primary care. *Patient Education and Counseling*, *48*(3), 243–252. https://doi.org/10.1016/S0738-3991(02)00177-5

Spitzer, D. L. (2005). Engendering health disparities. *Canadian Journal of Public Health = Revue Canadienne de Santé Publique*, *96*(Suppl 2), S78–S96. https://doi.org/10.1007/BF03403704

Statistics Canada. (2019). *Mental health care needs, 2018*. https://www150.statcan.gc.ca/n1/pub/82-625-x/2019001/article/00011-eng.htm

Statistics Canada. (2022). *Immigrants make up the largest share of the population in over 150 years and continue to shape who we are as Canadians*. The Daily. https://www150-statcan-gc-ca.proxy3.library.mcgill.ca/n1/daily-quotidien/221026/dq221026a-eng.pdf

Stewart, M., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., & Jordan, J. (2000). The impact of patient-centered care on outcomes. *The Journal of Family Practice*, *49*(9), 796–804.

Stewart, M., Brown, J. B., Weston, W. W., McWhinney, I. R., McWilliam, C. L., & Freeman, T. R. (2013). *Patient-Centered Medicine: Transforming the Clinical Method* (3rd ed.). CRC Press. https://doi.org/10.1201/b20740

Stewart, M., Brown, J., Weston, W., McWhinney, I. R., Freeman, T., & McWilliam, C. (2003). *Patient-centered Medicine: Transforming the Clinical Method* (Second). Radcliffe Publishing.

Verdonk, P., Benschop, Y. W. M., de Haes, H. C. J. M., & Lagro-Janssen, T. L. M. (2009). From gender bias to gender awareness in medical education. *Advances in Health Sciences Education*, *14*(1), 135–152. https://doi.org/10.1007/s10459-008-9100-z

World Health Organization. (2002). Gender and mental health. World Health Organization. https://apps.who.int/iris/handle/10665/68884

Yasui, M., Pottick, K. J., & Chen, Y. (2017). Conceptualizing culturally infused engagement and its measurement for ethnic minority and immigrant children and families. *Clinical Child and Family Psychology Review*, *20*(3), 250–332. https://doi.org/10.1007/s10567-017-0229-2

Zachariae, R., O'Connor, M., Lassesen, B., Olesen, M., Kjær, L. B., Thygesen, M., & Mørcke, A. M. (2015). The self-efficacy in patient-centeredness questionnaire – a new measure of medical student and physician confidence in exhibiting patient-centered behaviors. *BMC Medical Education*, *15*(1), 150. https://doi.org/10.1186/s12909-015-0427-x

APPENDICES

Appendix I: Overview of Interview Guide

Theme	Ask respondent to:
Clinician's Demographics	Describe your cultural background
Clinician's Practice	Describe your clinical practice
Demographics of Patients	Describe your patient population
General Encounter	Describe challenges in clinical practice including those related to intercultural and gendered factors
Ethnocultural Factors in the Clinical Encounter	Describe how a patient's ethnicity/culture might shape a clinical encounter concerning a mental health concern.
Gender Factors in the Clinical Encounter	Describe how gender may further shape a clinical encounter concerning a mental health challenge.
Assessment of Psychosocial distress	Describe a presentation of psychosocial distress that was particularly hard to diagnose and how you approached it. Describe if there were certain terms/metaphors/language used by the patient to describe their distress.
Patient-centered Clinical Method	Describe how you use the patient-centered clinical method to help detect and diagnose psychosocial distress. Specifically: • FIFE • Whole person • Common ground Describe if you think there are any cultural limitations in using the patient-centered clinical method.
Interpreters	Describe how interpreters assist you in encounters and when their role is particularly important.
Communicating the diagnosis	Describe how you communicate a mental health diagnosis to a patient. Describe how your patients typically react to this diagnosis.
Action/Treatment Plan	Describe how you develop treatment plans and if you make cultural or gendered adaptations.
Positionality / Self-reflection	Describe how/if your own background/culture/gender shapes the clinical encounter.
Closing	
Snowball Sampling	Recruit other potential participants.

Appendix II: Aperçu du Guide d'Entretien

Thème	**Objectif de la question**
Démographie des patients	Décrire leur patientèle
Éducation	Décrire leur éducation médicale spécialisée
Approche générale	Décrire les défis de la pratique clinique, y compris ceux liés aux facteurs interculturels
Facteurs ethnoculturels dans la rencontre clinique	Décrire comment l'ethnicité/culture peut influencer une rencontre clinique concernant la santé mentale.
Effet du genre dans la rencontre clinique	Décrire comment le genre peut influencer une rencontre clinique concernant la santé mentale.
Évaluation de la détresse psychosociale	Décrire une situation de détresse psychosociale particulièrement difficile à diagnostiquer et la manière dont elle a été abordée. Décrivez si le patient a utilisé certains termes ou un certain langage pour décrire sa détresse.
Approche du diagnostic	Décrire comment ils abordent une situation qu'ils soupçonnent d'être liée à la maladie mentale.
Méthode clinique centrée sur le patient	Décrire comment ils utilisent la méthode clinique centrée sur le patient pour aider à détecter et à diagnostiquer la détresse psychosociale. Décrire s'il existe des limites à l'utilisation de la méthode centrée sur le patient.
Communication du diagnostic	Décrire comment ils communiquent le diagnostic à un patient. Décrire comment les patients réagissent généralement à ce diagnostic.
Plan d'action/de traitement	Décrire comment ils élaborent leur plan de traitement.
Interprètes	Décrire comment les interprètes participent aux rencontres et quand leur rôle est particulièrement important.
Enseignement	
Positionnement / autoréflexion	Décrire son propre parcours et la manière dont il influence la rencontre clinique.
Conclusion	
Recrutement	Recrutement d’autre participants potentiels

Appendix III: English Translation of French Quotes

1. Dans beaucoup de cultures et dans plusieurs langues, le mot dépression n'existe pas. Donc j'ai déjà des interprètes qui m'ont dit le mot dépression, ça n'existe pas dans d'autres langues. Pourquoi ? Parce que tu n'as pas le droit d'être dans un mauvais état d'esprit mental. Ça ne fait pas partie de la culture… donc automatiquement, la seule façon de le manifeste*r* [est] ... psychosomatique. (#9)

   In many cultures and in many languages, the word "depression" does not exist. So, I have already had interpreters tell me that the word "depression" does not exist in other languages. Why is that? Because you are not allowed to be in a bad mental state. It's not part of the culture… so automatically, the only way to manifest it [is]… psychosomatically. (#9)

2. Je [serai] naïf… Je pense que ça marche très souvent « Écoutez, regarde-moi, je ne connais pas ça. Vous m'expliquiez un peu. Comment ça fonctionne ? Comment ça se vit chez vous, comment c'est au pays ? » Ça dépend toujours. Mais souvent, ça se peut être une façon d'ouvrir le sujet qui n'est pas très menaçante. (#12)

   I [will be] naive... I think it works very often "Listen, look at me, I don't know this. Explain it to me a little. How does it work? What's it like back home?" It always depends. But often, it can be a non-threatening way of opening the subject. (#12)

3. T'sais souvent ils vont nous dire qu'ils ont « pain all over the body » ou « headache » mais les mots pour moi qui me signalent une détresse, c'est quand il me parle d'intensité puis de durée. Donc « too much » puis « all the time » … Ça pour moi, c'est toujours [ces] deux

phrases qui sonnent une cloche de ok détresse psychologique à investiguer chez cette patiente-là, tout de suite. (#10)

You know, they'll often tell us they have "pain all over the body" or "headache", but for me, the words that signal distress, are when they talk about intensity and duration. So "too much" then "all the time" ... For me, it's always [these] two phrases that ring a bell of ok psychological distress to investigate in this patient, right away. (#10)

4. …Des fois le diagnostic se digère en plusieurs petits morceaux durant plusieurs rencontres que comprendre tout d'un coup la première fois. (#10)

   ...Sometimes the diagnosis can be digested in smaller pieces over several encounters, rather than being understood all at once the first time (#10).

5. J'ai appris aussi que souvent, c'est d'y aller par étapes. C'est de ne pas lui dire « Écoutez, c'est de l'anxiété, de la dépression ». Il y a des gens pour qui c'est des mots qui n'existent même pas… ce n'est pas si simple que ça. (#12)

   I've also learned that often, it's about taking it one step at a time. It's not telling him "Listen, it's anxiety, it's depression". Some people don't even know what those words mean... it's not as simple as that. (#12)

6. Maintenant, c'est ça, quelqu'un qui est très résistant à l'idée qu'il s'apprête à parler de santé mentale, bin, c'est correct de partir de la plainte qui les dérange parce que c'est ça qui va les faire revenir… C'est ça qui va faire qu'on va pouvoir se parler, puis bâtir un peu sur cette confiance-là, de valider le symptôme, d'explorer le symptôme d'un point de vue médical,

c'est ça que ça prend au départ pour les sécuriser, puis les amener à comprendre. Puis après ça, on va essayer de les faire cheminer dans le fait que ça se peut que des fois qu'il y a autre chose. (#12)

Now, someone who's very resistant to the idea of talking about mental health, well, it's a good idea to start with the complaint that's bothering them, because that's what's going to bring them back... That's what's going to allow us to talk to each other, and build on that trust, to validate the symptom, to explore the symptom from a medical point of view, that's what it takes at first to make them feel secure, and then to get them to understand. After that, we'll try to help them realize that there may be something else going on. (#12)

7. Je trouve que c'est plus difficile de, de faire en sorte que le patient partage spontanément ce qu'il pense ou ses attentes parce qu'il y a aussi une culture d'autorité qui est différente dans le sens que, t'sais souvent j'vais demander « oh mais qu'est-ce que tu penses qui cause ça » ou « qu'est-ce qui t'aiderais aujourd'hui ? » Puis j'vais souvent me faire répondre « je ne sais pas, vous, vous savez docteur. C'est vous le docteur » … ils vont vouloir que je prenne la décision par exemple. (#10)

I find it more difficult to, to get the patient to spontaneously share what he's thinking or his expectations because there's also a different culture of authority in the sense that, you know often I'll ask "oh but what do you think is causing this" or "what would help you today?" Then I'll often be told "I don't know, you know, Doctor. You're the doctor" ... they'll want me to make the decision, for example. (#10)

8. Il y a une situation qui va se reproduire quand même souvent… je décèle que ce patient vient toujours me voir pour, des maux physiques mais moi, je pense en fait que c'est probablement de l'anxiété ou de la dépression ou un choc post-traumatique. Ça va être difficile d'ouvrir cette porte-là avec un homme parce que, pour eux, ça peut être parfois vu comme un signe de faiblesse. C'est beaucoup plus facile de revenir à la maison pour dire j'ai mal au dos… j'ai vraiment aucun intérêt à livrer de l'information qui va faire sentir le, un patient plus petit… Donc des fois, des fois on va traiter des maux physiques, même si on sait, même si on croit que le, le réel problème n'est pas vraiment physique. (#10)

   There's a situation that's going to happen a lot... I can see that this patient always comes to see me for physical ailments, but I think it's probably anxiety or depression or post-traumatic shock. It's going to be difficult to open that door with a man because, for them, it can sometimes be seen as a sign of weakness. It's much easier to come home and say I've got a bad back... I really have no interest in delivering information that's going to make the, a patient feel smaller... So sometimes, sometimes we'll treat physical ailments, even if we know, even if we believe that the, the real problem isn't really physical. (#10)

9. Je pense qu'il est encore aujourd'hui les monsieurs ont plus de difficultés à accepter qu'ils ont un trouble de santé mentale puis qu'une travailleuse sociale ou un psychologue, ça pourrait les aider. Ils sont peut-être plus intéressés quand je leur dis qu'il faut qu'il recommence à aller voir leurs chums, retourner à la shop, tsais, à se forcer à retourner jouer au hockey. (#12)

   I think that even today, men have more difficulty accepting that they have a mental health problem and that a social worker or psychologist could help them. Maybe they're more

interested when I tell them that they need to start seeing their friends again, get back to life, you know, force themselves to go back to playing hockey (#12).

Appendix IV: Institutional Research Ethics Board Approval

McGill | Faculty of Medicine and Health Sciences | Faculté de médecine et des sciences de la santé

3655 Promenade Sir William Osler #633
Montreal, QC H3G 1Y6

3655, Promenade Sir William Osler #633
Montréal, QC H3G 1Y6

T: (514) 398-3124

August 1, 2022

Dr. Alayne Adams
Department of Family Medicine
5858 Ch. de la Côte-des-Neiges, Suite 300
Montreal QC H3S 1Z1

eRAP/Info-Ed File Number: **22-08-005** **IRB Internal Study Number: A08-B72-22B**

Study Title: *"Too much pain, doctor!": Capturing clinical cues of gender-mediated presentations of psychosocial distress among ethnoculturally diverse patients in primary care encounters*

McGill Principal Investigator: Alayne Adams

Student Investigator: Madison Leggatt

Dear Dr. Adams,

Thank you for submitting the above-referenced study for an ethics review, on behalf of your Master's student, Madison Leggatt.

As this study involves no more than minimal risk, and in accordance with Articles 2.9 and 6.12 of the 2nd Edition of the Canadian Tri-Council Policy Statement of Ethical Conduct for Research Involving Humans (TCPS 2 2018) and U.S. Title 45 CFR 46, Section 110 (b), paragraph (1), we are pleased to inform you that an expedited/delegated review was conducted and ethics approval for the study is provided 01-Aug-2022, valid until **31-Jul-2023**. The study proposal will be presented for corroborative approval at the next meeting of the Committee.

The following documents were reviewed and approved:

- Research protocol (IRB dated July 12, 2022);
- Clinician consent form (IRB dated July 12, 2022);
- Interpreter consent form (IRB dated July 12, 2022)

The Faculty of Medicine and Health Sciences Institutional Review Board (IRB) is a registered University Research Ethics Board working under the published guidelines of the Tri-Council Policy Statement 2, in compliance with the Cadre de référence en recherche avec des participants humains (MSSS, 2020), and the Food and Drugs Act (17 June 2001); and acts in accordance with the U.S. Code of Federal Regulations that govern research on human subjects (**FWA 00004545**). The IRB working procedures are consistent with internationally accepted principles of good clinical practice.

The Principal Investigator is required to immediately notify the Institutional Review Board Office, via amendment or progress report, of:

- Any significant changes to the research project and the reason for that change, including an indication of ethical implications (if any);
- Serious Adverse Effects experienced by participants and the action taken to address those effects;
- Any other unforeseen events or unanticipated developments that merit notification;
- The inability of the Principal Investigator to continue in her/his role, or any other change in research personnel involved in the project;
- A delay of more than 12 months in the commencement of the research project, and;
- Termination or closure of the research project.

The Principal Investigator is required to submit an annual progress report (continuing review application) on the anniversary of the date of the initial approval (or see the date of expiration).

The Faculty of Medicine and Health Sciences IRB may conduct an audit of the research project at any time.

If the research project involves multiple study sites, the Principal Investigator is required to report all IRB approvals and approved study documents to the appropriate Research Ethics Office (REO) or delegated authority for the participating study sites. Appropriate authorization from each study site must be obtained before the study recruitment and/or testing can begin at that site. Research funds linked to this research project may be withheld and/or the study data may be revoked if the Principal Investigator fails to comply with this requirement. A copy of the study site authorization should be submitted the IRB Office.

It is the Principal Investigator's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

The McGill IRB wishes you and your colleagues every success in your research.

Sincerely,

Roberta Palmour, PhD
Chair
Institutional Review Board

cc: Sylvain Baillet, PhD, Associate Dean, Research
Madison Leggatt
A08-B72-22B (22-08-005)

Appendix V: Institutional Research Ethics Board Approval – Continuing Review Acceptance

McGill | Faculty of Medicine and Health Sciences | Faculté de médecine et des sciences de la santé

3655 Promenade Sir William Osler #633
Montreal, QC H3G 1Y6

3655, Promenade Sir William Osler #633
Montréal, QC H3G 1Y6

T: (514) 398-3124

July 19, 2023

Dr. Alayne Adams
Department of Family Medicine
5858 Ch. de la Côte-des-Neiges, Suite 300
Montreal QC H3S 1Z1

eRAP/Info-Ed File Number: **22-08-005** **IRB Internal Study Number: A08-B72-22B**

Study Title: *"Too much pain, doctor!": Capturing clinical cues of gender-mediated presentations of psychosocial distress among ethnoculturally diverse patients in primary care encounters*

Dear Dr. Adams,

Thank you for submitting a Continuing Review Form to renew the above-referenced study's ethics oversight for one more year.

The study progress report was reviewed and an expedited re-approval was provided on July 19, 2023. The renewed ethics certificate is valid from **August 1, 2023 to July 31, 2024**. The status of your renewal submission including documents can be accessed on eRAP: https://infoed.is.mcgill.ca.

Investigators are reminded of the requirement to report all McGill IRB approved study documents to the Research Ethics Offices (REOs) of participating study sites, if applicable. Please contact the individual REOs for instructions on how to proceed. Research funds may be withheld and / or the study's data may be revoked for failing to comply with this requirement.

If any study modifications or unanticipated study developments occur prior to the next annual review, including study terminations, please notify the IRB promptly. Regulation does not permit the implementation of study modifications prior to IRB review and approval.

Kind regards,

Roberta Palmour, PhD
Chair
Institutional Review Board

cc: Madison Leggatt
A08-B72-22B (22-08-005)

Appendix VI: Consent Form

Study Title: "Too much pain, doctor!": Capturing clinical cues of gender-mediated presentations of psychosocial distress among ethnoculturally diverse patients in primary care encounters.

Principal Investigators
Dr. Alayne Adams
Department of Family Medicine, McGill University, 5858 Cote des Neiges, Montréal, Québec
Email: alayne.adams@mcgill.ca
Telephone: (514)-399-9002

Dr. Isabelle Leblanc
Department of Family, McGill University, UMF St-Mary's, Montréal, Québec
Email: isabelle.leblanc@mcgill.ca
Telephone: (514)-345-3511 ext. 5635

Co-Investigator
Dr. Jeannie Haggerty
Department of Family Medicine, McGill University, 5858 Cote des Neiges, Montréal, Québec
Email: jeannie.haggerty@mcgill.ca
Telephone: (514)-608-8352

Graduate Student Investigator
Madison Leggatt, MSc. Student
Department of Family Medicine, McGill University 5858 Cote des Neiges, Montréal, Québec
Email: madison.leggatt@mail.mcgill.ca
Telephone: (403)-829-1540

Funding
This research is supported by a Canadian Institute of Health Research Canada Graduate Scholarship – Master's Program (CGS M) and a CARE grant from St. Mary's Hospital Foundation.

Introduction
Mental health challenges are increasingly common in Canada and clinical care must respond to this reality. This means physicians must be given sufficient training to meet this need. However, research suggests that primary care physicians feel underprepared to address mental health concerns. Adding to this challenge, different ethnocultural understandings of mental health may result in different presentations of mental health challenges that physicians are unfamiliar with. For example, ethnocultural and gender-based differences may exist in how people present their mental health symptoms and psychosocial concerns to their physician. If these differences are not considered, mental health and illness challenges may be overlooked, or inappropriately treated. This qualitative study seeks to understand how culture and gender impact the presentation and recognition of mental health challenges in primary care. Interviews with interpreters who support ethnoculturally diverse patients in their appointments with family doctors will be held to explore their perceptions of how culture and gender influence the clinical

encounter. Interviews with experienced primary care physicians will identify practical strategies to help recognize and interpret ethnocultural and gender-mediated presentations of mental health challenges. The results of this study will inform a module to complement training in patient-centered care and improve the recognition and treatment of mental health challenges in ethnoculturally diverse populations.

Process
Should you choose to participate, the interview will be scheduled at your convenience. You will be provided with discussion points in advance of the interview and you will have the option to complete the interview in English or French. Prior to starting the interview, the graduate student (Madison Leggatt), or another member of the research team, will review the consent form with you and request your signature. If you consent, we will audio-record the interview for transcription purposes. The interview should take less than one hour complete and will explore what strategies you use to recognize and interpret ethnocultural and gender-mediated presentations of mental health challenges.

Subject Rights
Participation in the research study is completely voluntary. You will not face any consequences if you choose not to participate in this study and no explanation is necessary. If you choose to participate, you may choose not to answer any of the interview questions and or can stop the interview at any point, with no consequences or explanation necessary. Furthermore, you may choose to withdraw from the study at any point, with no consequences or explanation necessary.

Discomforts and Risks
Apart from the time required to participate, we believe this is a minimal risk project and we have not detected any risk with participation, nor is it anticipated that the research will inflict any harm.

Benefits
There will be no financial compensation for your participation, but we offer you a gift card as a token of appreciation and hope that the information will benefits other physicians to better address the mental health needs of ethnoculturally diverse patients. Should you choose to stop the interview at any point, this will not impact the provision of the gift card.

Confidentiality
No identifying information will be recorded on any research documentation used for analysis. No one except for the research team will have access to the recording, which will be stored on a secure platform and destroyed after the study. Any nominal information (including the consent form) will be stored in a locked cabinet in facilities with entry restrictions. For all quotations used in publications, pseudonyms will be used.

Information Package
You will be emailed a copy of the consent form. Upon your request, all study findings will be shared with you.

Contact Information

Should you have any questions prior to or after completing the study, you may contact any member of the research team. Our contact information can be found at the top of this form.

Ethical Approval
This study has obtained ethics approval from McGill University's ethics review board.

Audio Recording
Please check the following, regarding the audio-recording of the interview:

- I agree to have my interview audio recorded.
  ☐YES ☐NO
- I agree to the use of anonymous quotations in any thesis or publication that comes of this research.
  ☐YES ☐NO

Participant
By signing this consent form, I agree that:

- *The study and its purpose have been adequately explained to me;*
- *Any potential harms and or benefits from participating in the study have been adequately explained to me;*
- *I have had the opportunity to ask any questions and all of my questions have been adequately addressed;*
- *My rights as a participant have been explained to me; and*
- *I agree to participate in this research study.*

_____
Print Name

_____
Signature of Participant

_____
Dated

Appendix VII: Formulaire de consentement

Titre de l'étude : « Too much pain, doctor! » : identifier les indices cliniques des représentations spécifiques au genre de la détresse psychosociale chez des patients issus de communautés ethnoculturellement diverses lors de rencontres de soins primaires.

Chercheuses principales

Dr Alayne Adams
Département de Médecine Familiale, Université de McGill, 5858 Côte des Neiges, Montréal, Québec
Courriel : alayne.adams@mcgill.ca
Téléphone : (514) -399-9002

Dr Isabelle Leblanc
Département de Médecine Familiale, Université de McGill, UMF de St Mary, Montréal, Québec
Courriel : isabelle.leblanc@mcgill.ca
Téléphone : (514) -345-3511 ext. 5635

Co-chercheuses

Dr Jeannie Haggerty
Département de Médecine Familiale, Université de McGill, 5858 Côte des Neiges, Montréal, Québec
Courriel : jeannie.haggerty@mcgill.ca
Téléphone : (514) -608-8352

Étudiante chercheuse à la maîtrise

Madison Leggatt, Étudiante à la maîtrise
Département de Médecine Familiale, Université de McGill, 5858 Côte des Neiges, Montréal, Québec
Courriel : madison.leggatt@mail.mcgill.ca
Téléphone : (403) -829-1540

Financements

Cette recherche est financée par une bourse universitaire de l'Institut Canadien de Recherche en Santé – Programme de maîtrise (CGS M) et une subvention CARE de la Fondation de l'Hôpital St Mary.

Introduction

Les enjeux de santé mentale sont de plus en plus communs au Canada et les soins cliniques doivent répondre à cette réalité. Les médecins doivent donc bénéficier d'une formation appropriée pour répondre à ce besoin. Cependant, la recherche suggère que les médecins de soins primaires ne se sentent pas suffisamment préparés pour répondre aux préoccupations touchant la santé mentale. Ajoutées à cela, les différences ethnoculturelles de compréhensions de la santé mentale peuvent entraîner différentes représentations des problèmes de santé mentale avec lesquels les médecins ne sont pas familiers.

Par exemple, des différences ethnoculturelles et de genres peuvent exister dans la façon dont les personnes présentent leurs symptômes de santé mentale et leurs préoccupations psychosociales à leur médecin. Si ces différences ne sont pas prises en compte, les problèmes de santé mentale et de maladie peuvent être négligés, ou traités de manière inappropriée. Cette étude qualitative vise à comprendre comment la culture et le genre influencent la représentation et la reconnaissance des enjeux de santé mentale en soins de premières lignes. Des entrevues avec des interprètes aidant diverses populations ethnoculturelles lors de leurs rencontres avec les médecins de famille, seront réalisées pour explorer leurs perceptions quant à la façon dont la culture et le genre influencent la rencontre clinique. Des entrevues avec des médecins de soins primaires expérimentés permettront d'identifier des stratégies pratiques pour aider à reconnaître et interpréter les représentations ethnoculturelles et de genre des enjeux de santé mentale. Les résultats de cette étude vont permettre d'élaborer un module pour compléter la formation en soins centrés sur la Personne et améliorer la reconnaissance et le traitement des problèmes de santé mentale dans diverses populations ethnoculturelles.

Processus
Si vous choisissez de participer, l'entrevue sera planifiée à votre convenance. On vous fera parvenir à l'avance les thèmes de l'entrevue qui seront discutés et vous pourrez choisir de faire l'entrevue en anglais ou en français. Avant de commencer l'entrevue, l'étudiante à la maîtrise (Madison Leggatt), ou un autre membre de l'équipe de recherche relira le formulaire de consentement avec vous et vous demandera de le signer. Si vous consentez, nous enregistrerons l'entrevue à des fins de transcription. L'entrevue devrait durer moins d'une heure et explorera les stratégies que vous utilisez pour reconnaître et interpréter les représentations de genre et ethnoculturelles des enjeux de santé mentale.

Droits du participant
La participation à une étude de recherche est complètement volontaire. Vous ne subirez aucune conséquence si vous choisissez de ne pas participer à l'étude et aucune explication ne sera nécessaire. Si vous décidez de participer, vous pouvez choisir de ne pas répondre à certaines questions de l'entrevue et/ou vous pouvez arrêter l'entrevue à n'importe quel moment, sans aucune conséquence ou explication nécessaire. De plus, vous avez la possibilité de vous retirer de l'étude à n'importe quel moment, sans aucune conséquence ou explication nécessaire.

Désagréments et risques
Mis à part le temps requis pour participer à l'étude, nous pensons qu'il s'agit d'un projet à risque minimal. Nous n'avons identifié aucun risque lié à la participation et nous ne prévoyons aucun dommage dû à la recherche.

Indemnités
Il n'y aura aucune compensation financière pour votre participation, mais il vous sera offert une carte cadeau en guise de remerciement. Nous espérons que ces informations permettront à d'autres médecins de mieux répondre aux besoins de santé mentale de leurs patients issus de la diversité ethnoculturelle.

Confidentialité
Aucune information d'identification ne sera enregistrée sur les documents de recherche utilisés pour l'analyse. Personne à part les membres de l'équipe de recherche n'aura accès aux enregistrements, qui seront sauvegardés sur une plateforme sécuritaire et détruits après l'étude. Toute information nominative (dont le formulaire de consentement) sera gardée dans une armoire fermée à clé dans l'établissement, accessible qu'aux personnels autorisés. Pour toutes les citations utilisées dans les publications, des pseudonymes seront utilisés.

Dossier d'information
Une copie du formulaire de consentement vous sera envoyée par courriel. A votre demande, nous vous partagerons les résultats de cette étude.

Contact
Si vous avez des questions avant ou après avoir participé à l'étude, vous pouvez contacter les membres de l'équipe de recherche. Nos informations de contact peuvent être retrouvées en haut de ce document.

Approbation éthique
L'étude a obtenu une approbation éthique du comité d'éthique de l'Université de McGill.

Enregistrement audio
Veuillez cocher les réponses qui s'appliquent concernant l'enregistrement audio de l'entrevue :

- J'accepte que l'entrevue soit enregistrée
  ☐OUI ☐NON
- J'accepte que mes dires soient cités anonymement dans des thèses/mémoires ou publications qui ressortiront de cette recherche
  ☐OUI ☐NON

Participant
Par la signature de ce formulaire de consentement, je reconnais que :

- *L'étude et son but m'ont été expliqués de manière adéquate*
- *Tout inconvénient ou bénéfice potentiel à participer à cette étude m'a été expliqué adéquatement*
- *J'ai eu la possibilité de poser des questions et toutes mes questions ont été répondues de manière adéquate*
- *Mes droits en tant que participant m'ont été expliqués, et*
- *J'accepte de participer à cette étude de recherche.*

_____
Nom

_____
Signature du participant

_____
Date