# Providing Mental Health Care Across Cultures: A Qualitative Study to Understand Perspectives and Experiences of PEARLS Coaches Delivering Late-Life Depression Care

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A thesis

submitted in partial fulfillment of the

requirements for the degree of

Master of Public Health

University of Washington

2026

Committee:

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Program Authorized to Offer Degree:

Global Health

University of Washington

## Abstract

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Around 31.74% of older adults experience late-life depression. PEARLS is an evidence-based coaching intervention effective in reducing depression symptoms in older adults. Due to racial/ethnic diversity in the United States, culturally responsive care is essential for effective treatment. Evidence is inconclusive regarding whether racial/ethnic cultural match and cultural mismatch of coach and client influences intervention engagement and mental health outcomes. This study aims to highlight the experiences of PEARLS coaches providing cross-cultural care. Participants were recruited using quota and snowball sampling technique. Sixteen PEARLS coaches were interviewed virtually using a semi-structured interview approach. Data was analyzed using a hybrid deductive and inductive approach and thematic analysis was conducted to identify salient findings. Six themes were identified through thematic analysis. These six themes were nested within two overarching themes. They illustrated that while cultural match promotes establishing therapeutic relationships, it comes with challenges such as blurred professional boundaries and more evident mental health stigma. On the contrary, cultural mismatch can lead to initial hesitancy to engage with PEARLS, however, this challenge can be overcome by building rapport using effective interpersonal skills and focusing on shared humanity of clients. In conclusion experiences of PEARLS coaches highlight challenges in delivering cross-cultural care. The findings illustrate the need for additional training and on-going support to ensure cultural responsiveness and further health equity.

## Introduction

Global population demographics are shifting significantly with older adults, that is individuals aged 65 years or older, constituting a bigger proportion of the population. United Nations Population Division (UNPD) estimates that currently 857 million individuals are aged 65 years and over and this number is expected to nearly double to 1.58 billion by 2050 [1]. Similar to global trends, population demographics in the United States (US) are also shifting. Currently, 10% of the total global population is 65 years or older. Whereas, in the US the percent of total population 65 years and older is higher than the global average at 18% [2]. Around 58 million individuals living in the US were aged over 65 years old in 2022. This number is expected to increase to 82 million, around a 42% increase, by 2050 [3].

As population demographics continue to shift toward older age groups, it is increasingly important to recognize and respond to the unique health needs of older adults. Public health infrastructure must be strengthened to support the prevention, identification, and treatment of common conditions and disorders. Among the many health challenges affecting older adults, depression is one of the most prevalent, contributing substantially to the global burden of disease and a leading cause of disability worldwide [4]. An estimated 31.74% of older adults experience late-life depression [5]. Several risk factors contribute to the development of depression in older adults including social isolation, bereavement, loneliness, chronic illness diagnosis, low socioeconomic status, financial hardship, reduced sense of purpose and elder abuse [6,7]. Impact of depression on quality of life is significant, with patients reporting poorer psychological functioning including self-perceived health and life satisfaction, physical health and social health [8]. As depression significantly impacts the quality of life, it is critical to ensure that mental health care is culturally responsive and aligns with the social, cultural and emotional needs of diverse communities [9].

Disparities in depression prevalence are observed by sex and racial/ethnic groups. Women are twice as likely as men to suffer from depression [10]. Historically disparities exist for diagnosis and treatment of depression in minority groups. A 2023 nationally representative survey reported that 50% of Caucasian adults mentioned receiving mental healthcare as compared to 39% African American and 36% Hispanic adults. Individuals from minority groups including 55%

Asian and 46% African American adults reported difficulty in finding providers who could understand their experiences and cultural backgrounds as compared to 38% Caucasian individuals [11]. Minority groups were also underdiagnosed for depression as compared to Caucasian individuals, due to differences in care affordability, help-seeking behaviors, cultural beliefs regarding depression and access to culturally and linguistically responsive care. People of color are more likely to experience life stressors such as discrimination and racism which are attributed to poor well-being and mental health [12].

Treatment of depression is necessary to improve quality of life and aims at reducing symptoms until patients reach a remission state. Treatment options include pharmacotherapy, somatic therapy and psychotherapy [13]. The Program to Encourage Active, Rewarding Lives or PEARLS is one such evidence-based problem-solving and behavioral activation therapy for treating depression and persistent depressive disorder in older adults. The PEARLS intervention consists of 6 to 8 one on one sessions conducted over 4 to 5 months by trained community-based social service providers referred to as PEARLS coaches [14]. PEARLS sessions are focused primarily on teaching client's problem-solving skills, and physical and social activation. The physical activation component assists clients in developing a physical activity plan consistent with national recommendations for daily activity. While, the social activation component is focused on increasing client's social interaction outside the home and specifically encourages peer support [14]. The PEARLS intervention has been shown to significantly reduce depressive symptoms and improve health status in older adults [15,16]. The PEARLS intervention was piloted in the late 1990's in Washington State by two local agencies: Area Agency on Aging for Seattle and King County and Senior Services of Seattle/King County. Since then, PEARLS intervention has been implemented by 170 organizations in 36 states across the US and so far served more than 30,000 older adults [17].

A variety of factors strongly shape how clients experience depression interventions like PEARLS and whether these interventions positively influence their mental health outcomes. These factors can influence the social validity of an intervention, including whether clients perceive it as acceptable, appropriate, and valuable, particularly among culturally diverse communities. The three major categories of influence include intervention factors, provider factors, and client factors.

Intervention factors include perceived cultural relevance, complexity, design quality and therapeutic efficacy of PEARLS [18]. These factors directly influence clients' experiences and outcomes such as mental health outcomes, adherence and intervention acceptability. Moreover, it is also important to consider individual client factors such as their attitudes towards intervention, subjective norms, intention for change, and belief in self-efficacy [19]. An important category of influence is provider factors, which are the focus of this study. Provider factors such as their cultural identity, cultural humility, trust formation, kinship and relatability with clients all influence client experiences which ultimately influence mental health outcomes. The influence of provider identity and client experiences may be explained through the cultural identity theory (CIT) [20]. Figure 1 illustrates these factors that may influence the social validity, engagement and effectiveness of PEARLS intervention.

According to CIT, formation of an individual's sense of self is influenced by their cultural background, including family norms, religion, tradition, values and shared history. It suggests that identity is co-constructed through communication and that culture influences interpretation of information, building trust and engaging in relationships [21]. CIT provides a framework, within the healthcare system, for understanding why culture match commonly in the form of racial/ethnic match may influence treatment process (engagement and retention) and treatment outcomes. Culture matching may improve communication due to shared meaning and need for fewer explanations, client-coach trust and comfort leading to better treatment outcomes [22].

Currently, research on racial/ethnic matching is inconclusive due to mixed findings [22]. Some studies have found that racial/ethnic matching is not a strong predictor for improved treatment outcomes, rather it is a strong predictor for improved treatment processes such as retention of clients and engagement [21]. One study suggests that matches in acculturation and ethnicity of provider positively influenced both treatment outcomes and process due to experiential similarity which increases coaches' credibility for clients [23]. Clients may believe that those facing similar stressors are better equipped to aid them. Similarly, attitudinal similarity particularly within culturally matched clients and providers affects perceptions of support leading to stronger client-coach relationships leading to better mental health outcomes [23]. Cultural matching may also remove the barrier of face concern (individuals wanting to protect self- or community image) leading to more open and vulnerable client-provider conversations.

In contrast several studies indicate that racial/ethnic matching is not a strong predictor, rather a providers multicultural understanding, cultural humility and awareness are stronger predictors for client success. A study involving youth found that therapists who demonstrated high multicultural awareness formed stronger therapeutic alliances leading to greater resilience amongst their clients, regardless of racial/ethnic match. Conversely, a lack of cultural understanding and humility may lead to misdiagnoses and inadequate treatment recommendations [24].

In light of this evidence, there is a gap in our understanding of how coach-client cultural match or mismatch may influence the PEARLS intervention. This study aims to explore how PEARLS providers experience and navigate delivering care to culturally diverse clients within and outside their own cultural backgrounds. It also aims to identify what challenges and facilitators related to cultural match or mismatch coaches encounter during intervention delivery. This information can help identify and address gaps in training and support available to PEARLS providers.

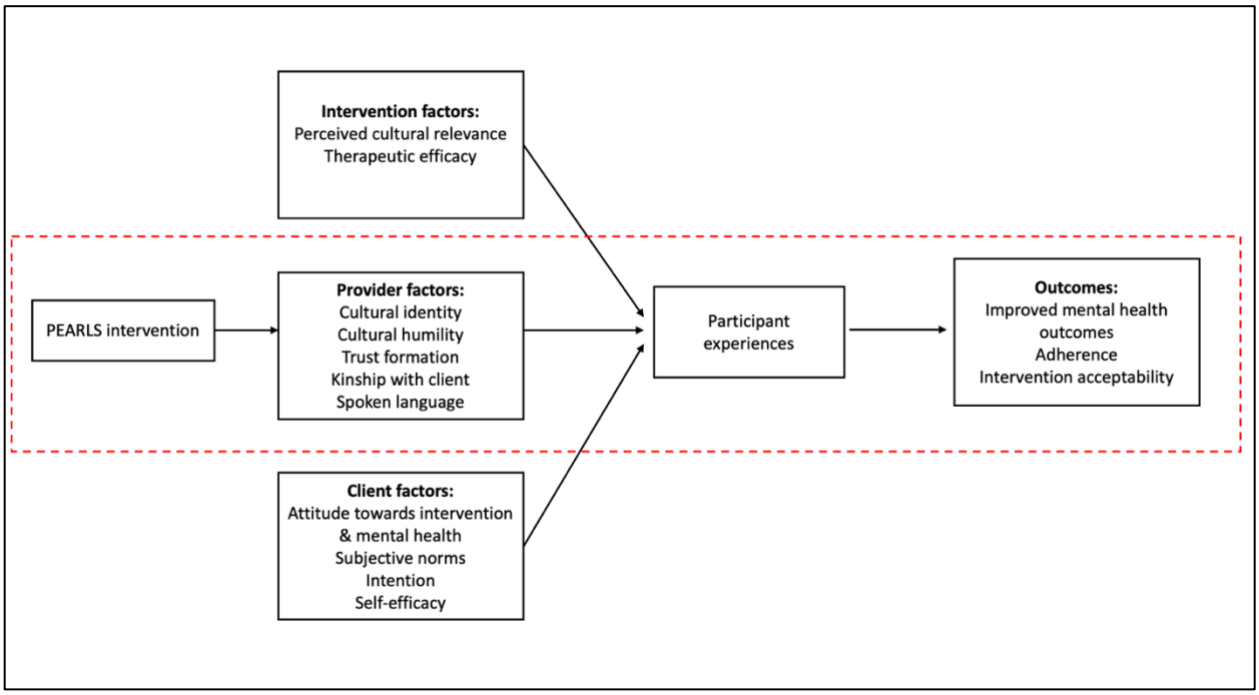


*Figure 1 Conceptual model adapted from CIT*

## Methods

### Study design

This study employed a qualitative research design to explore the perspectives and experiences of PEARLS coaches delivering cross-cultural care to older adults screening positive for depression. This study sought to understand the experiences of PEARLS coaches through individual semi-structured interviews conducted virtually over zoom.

### Participant recruitment

The sampling frame included 100 PEARLS coaches who were actively delivering the intervention across participating organizations. Most coaches identified as female, held a bachelor's or master's degree as their highest level of education, and had professional backgrounds in social work. Coaches most commonly identified as Black/African American, White/Caucasian, Hispanic/Latinx, or Asian. The majority had been working with their organizations for one to three years.

Quota and snowball sampling were used to recruit participants [25]. Recruitment was conducted through PEARLS program listserv, announcements during PEARLS technical assistance calls and supervising researcher reaching out directly to PEARLS coaches within their network. Participants were also requested to share the study with their colleagues. Coaches with diverse cultural backgrounds and delivering care to Black Indigenous and People of Color (BIPOC) or s racial/ethnic minorities were sampled. Racial and ethnic minorities include all populations who are socially disadvantaged and medically underserved. Typically, racial/ethnic minorities refer to all populations other than non-Hispanic white people [26]. Although culture encompasses a wide range of identities and social experiences, for the purpose of this study, culture primarily refers to racial/ethnic identity and the experiences of minoritized populations.

Interested individuals self-identified using a Microsoft questionnaire, designed to ensure participants met the inclusion criteria prior to scheduling interviews. Eligible participants were scheduled for interviews via email. A $50 USD Tango gift card was provided to each participant after the interview as compensation for their time.

## Study setting and participant sampling

Participants were purposively recruited from across the US and a variety of different organizations to ensure diversity in experiences providing cross-cultural care [27]. Organizations may have varying access to training and resources which may influence coach experiences.

According to the inclusion criteria, all participants were 18 years or older, proficient in English, actively delivering PEARLS intervention and living in the US. Participants were sampled to ensure maximum variability in racial/ethnic identity of participants and the racial/ethnic identity of clients they served. Participants were excluded if they were younger than 18 years old or did not have an active caseload of clients.

## Data collection

A semi-structured interview guide was designed to explore perspectives and experiences of PEARLS coaches, specifically barriers and facilitators experienced while providing care to culturally matched and culturally mismatched clients. Sixteen interviews were conducted and recorded virtually, between 7$^{th}$ April and 4$^{th}$ May 2026, over Zoom. All interviews were conducted in English. Interview length ranged between 15 to 56 minutes, with a mean duration of 36 minutes. Early interviews were used to modify the interview guide for clarity, wording and interview flow. Interviews were audio and video recorded subject to participants verbal consent. Recorded interviews were transcribed using Rev, an online transcription service.

Sociodemographic data including participant's age, gender, years of education, geographical location, participant's cultural identity, cultural identity of clients served and years providing PEARLS were collected using a Microsoft questionnaire post-interview completion.

All data was stored in a secure password protected OneDrive account with limited access. Additionally, participants were given a unique participant ID which was used to label audio and transcript files to maintain anonymity.

## Reflexivity

The primary researcher for this study is a woman of color from Pakistan with an educational background in public health and healthcare biotechnology. Positionality of interviewer may have influenced the research process particularly participant engagement during individual interviews.

Being a woman of color may have aided in fostering trust and openness when discussing experiences related to culture and identity with participants of color.

To mitigate any influence of implicit biases and assumption during data collection, primary researcher asked open-ended questions to allow participants to describe the experiences most important and relevant to them in their own words. Analysis was conducted independently by primary researcher; however, all coding decisions, discrepancies and emerging themes were regularly discussed with supervising team. This strengthened analytic rigor, supported reflexivity and helped ensure that interpretations were grounded in data rather than the researcher's positionality or assumptions.

**Data analysis**

A hybrid coding approach employing both deductive and inductive coding was used to analyze interview transcripts [28,29]. A preliminary deductive codebook was developed using key concepts and domains identified *a priori* based on the research question and conceptual model. The *a priori* themes are outlined in the provider factors section of figure 1. Inductive codes were generated by identifying new ideas and concepts not previously identified, through open coding of transcripts.

After codebook was finalized, transcripts were coded in Dedoose 10. For thematic analysis, coded data was interpreted through systematic pattern recognition within and across participants. Two primary strategies were used to guide the interpretation process: similarities and differences, and repetitions. A cutting and sorting strategy was used to help refine themes by grouping together related concepts [30].

# Results

## Participant demographics

*Table 1 Participant characteristics (n = 16)*

| ***Characteristic*** | ***n = 16 (%)*** |
|---|---|
| **Role with PEARLS** *(multiple answers possible)* | |
| Coach/Counselor | 15 (63) |
| Program manager | 5 (21) |
| Clinical supervisor | 1 (4) |
| Data manager | 2 (8) |
| Other | 1 (4) |
| **Length (time) conducting PEARLS** | |
| <1 year | 3 (19) |
| 1-3 years | 7 (44) |
| 4-6 years | 2 (13) |
| 7 years or more | 4 (25) |
| **Age** | |
| 18-29 | 1 (6) |
| 30-39 | 5 (31) |
| 40-49 | 2 (13) |
| 50-59 | 2 (13) |
| 60-69 | 4 (25) |
| 70 or above | 2 (13) |
| **Gender** | |
| Female | 13 (81) |

| | |
|---|---|
| Male | 3 (19) |
| **Level of education** | |
| Some college | 1 (6) |
| 2-year college degree (Associates) | 2 (13) |
| 4-year college degree (BA/BS) | 7 (44) |
| Master's degree | 6 (38) |
| **Professional/educational background** *(multiple answers possible)* | |
| Medicine | 1 (5) |
| Social work | 7 (33) |
| Behavioral/mental health | 4 (19) |
| Gerontology/aging | 3 (14) |
| Other professions | 6 (29) |
| **Geographical location** | |
| Northeast | 2 (13) |
| South | 3 (19) |
| West | 11 (69) |
| **Participant's race/ethnicity** *(multiple answers possible)* | |
| Asian | 2 (12) |
| Black/African American | 4 (24) |
| White/Caucasian | 5 (29) |
| Hispanic or Latino/a/x/e | 6 (35) |
| **Client's race/ethnicity** *(multiple answers possible)* | |
| American Indian/Alaskan Native | 3 (6) |
| Asian | 5 (10) |

| | |
|---|---|
| Black/African American | 10 (20) |
| Native Hawaiian/Pacific Islander | 2 (4) |
| White/Caucasian | 16 (33) |
| Hispanic or Latino/a/x/e | 10 (20) |
| Middle Eastern/North African | 3 (6) |
| **Frequency of providing care to clients outside culture** | |
| Always | 5 (31.3) |
| Often | 9 (56.3) |
| Rarely | 2 (12.4) |

**Participant demographics**

Sixteen PEARLS coaches participated in this study, the demographic data of which is presented in Table 1. A majority of participants self-identified as female (81%), were 30-39 years old (31%), and many (44%) had been delivering the PEARLS intervention for 1-3 years. Most participants held either a 4-year college degree (44%) or a master's degree (38%), in a wide variety of disciplines including social work (33%), behavioral/mental health (19%), gerontology/aging (14%), and medicine (5%) and others (29%). Participants were primarily located in the West (69%), with some representation from South (19%) and Northeast (13%) of US. Self-reported racial/ethnic identities of participants varied, 35% were Hispanic or Latino/a/x/e, 29% were Caucasian, 24% were African American and 12% were Asian. There was even greater variability in client's race/ethnicity as reported by participants. A majority (33%) of clients served were identified as Caucasian, 20% as Hispanic or Latino/a/x/e. 20% as Black/African American, 10% as Asian American, 6% as Indian and Alaskan Native, 6% as Middle Eastern or North African, and 4% as Native Hawaiian or Pacific Islander. Most coaches (81%) provided care to both culturally matched and mismatched clients, 12.5% of coaches provided care to culturally mismatched clients only and 6.5% of coaches provided care to culturally matched clients.

**Thematic analysis**

There were two overarching domains with six major themes identified through thematic analysis and  All six themes were nested within the two overarching domains. To illustrate each theme, representative quotes by participants are included. Quotes by participants are identified by their unique participant ID.

**Domain 1: Coach-client cultural match is a double-edged sword**

The first domain includes themes that demonstrated that cultural match has both advantages and disadvantages. Coach-client cultural match does not ensure that delivery of PEARLS will occur without significant challenges. This is why coach-client cultural match has been dubbed as a "double-edged sword". A double-edged sword refers to situations which have both favorable and unfavorable consequences.

**Theme 1:** Shared identity, values and experiences make it easier to establish therapeutic relationships for culturally matched coaches and clients, leading to better engagement with PEARLS.

Majority of the coaches described how it was easier to establish a relationship when a cultural match existed. Cultural matches promote understanding, trust and comfort between coach and client. This trust leads to easier rapport building and when BIPOC clients meet a coach of color they believe they will be well taken care of. Clients are more trusting when a cultural match exists. Clients shared identity with the coach makes them more comfortable expressing their feelings, experiences and problems.

*"I'd say for me, you know being Black and them being Black, there's kind of the automatic sense of, okay, she's one of me in a sense. And so, a little bit more trust to a degree for some of them. It's a really good flow of conversation." – CHMI*

*"I'll say just thinking back, when I was going in person for my PEARLS visit. It seemed as though that people that shared the same ethnicity as me, black and brown elders felt more comfortable with me being in their home because I look like them or look like their granddaughter or daughter or something of that nature." – DEDA*

When coaches and clients are culturally matched, coaches feel more confident in interacting with clients.

*"To be honest with you, it might be a little bit easier just having the knowledge that my experience is likely going to be more similar to my clients. So I would say there's a slightly higher confidence level when interacting with them." – JOWA*

Shared values and experiences of coaches with clients helps coaches identify and understand their client's priorities and understand their client's struggles from a historical perspective. Shared identity induces a sense of familiarity and comfort, as though coaches are interacting with a close family member.

*"Clients in the same culture, because in the African American and Black culture, we all have this common thread where we have been villainized, victimized, everything else by white supremacy in this society from the cradle to the grave. So, when I engage with Black senior citizens like myself, it's more like a family type, feeling that we don't have to go through a lot of the formalities, you know what I mean?" - PAJA*

Coach-client cultural matches also help bridge gaps in communications. Coaches report that interacting with clients from a shared culture requires less effort as client's do not need to expend energy on explaining themselves, there is less need for formalities or small talk, and coaches can understand the intended or underlying meaning behind client's words. The use of metaphors or similes, shared understanding of cultural concepts, and common "lingo" or vernacular also makes it easier for coaches and clients to communicate.

*"I can speak their language and I understand where they come from and how culturally everything is, so that helps….and yeah, kind of speaking in their lingo" – EDCO*

*"There are some instances where we have a shared understanding od, for example, language - wise some concepts and ideas that are culturally similar….Spanglish is one of the things that comes to mind. Ans so we'll be speaking in English and then they're unable to explain something fully. So they'll of speak something or describe something in Spanish, and then we have a, I get what you're saying, kind of moment between the two of us." - LEGA*

**Theme 2:** Feelings of kinship make it difficult for coaches to maintain professional boundaries with culturally matched clients and may lead to coach distress due to resonance of lived experiences.

While cultural match can be advantageous in trust formation and establishing the therapeutic relationship it also attributes to difficulties. These challenges are predominantly acknowledged by BIPOC providers.

Negative experiences of clients, for example  experiences with racism, resonate with a coach's own life experiences leading to distress. Some coaches feel an immediate sense of relatability and connection during cultural match  which may evoke remembrance of an elder or community member.

*"When you are helping somebody from your culture, it makes it more personal because you would see your grandmother in it or an aunt or your mother, somebody that kinda reminds you of yourself." – EDCO*

*"I guess, more deeply personal perspectives, it is just making sure I don't go out of the scope of my job because when I hear my clients talk and they are aunties and grandmother and so on and so forth, and it reminds me of my own family, And I'm just like, "Oh my gosh, I wish I could just go pick her up and take her to the grocery store, take her to a doctor's appointment," but I can't do that. That's out of my scope." – DEDA*

Professional boundaries become distorted when coaches and clients are culturally matched. Clients may become overly attached or dependent on coaches, which is particularly worrisome as PEARLS is a short-term intervention. Coaches also mentioned that clients may call outside of work hours. Clients may demand a more personal relationship or want to know intimate information about coaches beyond what is appropriate for a professional relationship.

*"I noticed with my black clients, they always want a more personal connection. In other words, can we be friends? Can I get your phone number? Can we go places together? Can you come to this event? And which is cool but at some points it doesn't bother me because I am open to new experiences...but the tendency is to lean too heavily on my support" – PAJA*

Terms of endearment used by clients may further cloud the coach-client therapeutic relationship. Since the PEARLS intervention is geared towards older adults, use of informal terms of endearment may indirectly reinforce that clients are knowledgeable and have no need for continuous learning and acquiring skills.

*"I don't like it [when they call me Mija], and I, I think that that clouds our, our relationship. And then granted, this is in therapy, and I, I, I'm a therapist, um, but I don't like it because then it makes ... It reinforces this idea that they're coming in as the expert. In therapy, they are the expert, but here, I'm the coach, I'm teaching you something. So when they're coming in and they're like, "Mija or Corazon, they wanna reemphasize that they're mature, they're older." – JELO*

Based on coaches' cultural identity, clients may assume that a coach's values align with their own. This can cause coaches' unease when values or perceptions are controversial.

*"I've had the experience where I've had Caucasian client that have had, in my view, problematic perceptions. And it's been assumed because of my appearance that I am in agreement with that, and that can be very uncomfortable." - JOWA*

**Theme 3:** Mental health stigma is more evident to a coach when a cultural match exists as opposed to cultural mismatch.

Many coaches mention that mental health is stigmatized, making outreach and engagement difficult. Coaches report using idioms of distress or symptom focused language when engaging clients to circumvent resistance of clients to words such as depression and anxiety. Coaches mention asking questions related to sleeping patterns, eating patterns, and worrying to effectively engage clients while minimizing stigma.

*"The big words like you will say depression and things like that; you kinda don't because they don't understand that or they will say "I'm not depressed." But if you ask them, like, "Oh are you feeling down? Do you have trouble sleeping?" or these questions are more simple things that they can say, "Yeah, I don't eat well, or I don't sleep well." So yeah, because I have understand and seen that, you know depression and mental illness is kinda like a taboo topic in these communities." - EDCO*

Stigma is often rooted in cultural norms that promote independence, resilience, and discourage help-seeking behavior. Symptoms of poor mental health may also be normalized as a part of everyday life that must be endured.

*"I had a hard time to outreach, because they didn't accept it. They didn't accept they are a little having depressive symptoms. They don't like it. They say I am okay...Also they say feeling down is the regular life. Life is up and down. So that one is regular, even though I am feeling a little down sometimes, but it will be a cycle. I'll be good and so they refuse. I can say they refuse to keep going, talking about that." – CHCH*

*"So understanding and validating their emotions and their experiences, even though our culture really upholds the idea that you should just sort of muscle through things or that it's a matter of personal effort. And so if you just try hard enough, you should be able to get through it." – LEGA*

Patient-level stigma is much more evident to a coach when coach-client cultural match exists. Coaches who shared client's cultural backgrounds described stigma being present within their community. However, coaches outside the same cultural context did not identify stigmatizing behaviors within those same communities. This is well illustrated by the highlighted participant quotes. A coach from the Korean community mentions that Korean clients display stigma towards mental health while African American clients are very open to care. In contrast, an African American coach mentions that they have received feedback to use idioms of distress instead of the word depression which indicates stigma within the community.

*"So that one is Korean community is a little, me too, I was very unfamiliar with depressive symptoms, like that kind of wording….for me Chinese speaker and Black speaker were more easier. My perspective, they accept everything a little more comfortably, more easily." – CHCH*

*"When I am talking to a person of my same ethnicity [Black/African American], I normally don't use the word depression. I normally say going through transitions or feeling down or feeling low, feeling sad or unhappy, because that feedback that I have received from my people…is that word depression sometimes people think that they have to be diagnosed with it or that it mean something is really wrong." – DEDA*

**Domain 2: Coach-client cultural mismatch is difficult but not doomed**

The second domain includes themes that demonstrate that while some challenges are inherent with a coach-client cultural mismatch, these challenges can be navigated to promote client engagement with the intervention.

**Theme 4:** A perceived lack of shared experiences and values between coach and client may lead to reluctance to engage with PEARLS when cultural mismatch exists.

Several coaches mention that clients' perceptions of coaches' inability to understand their lived experiences makes it difficult to engage them. Clients may deem coaches ineffective in aiding problem solving due to a lack of understanding regarding client issues. This in turn may make clients more hesitant to share their experiences.

*"That's very difficult. It becomes a challenge. I find that I get that a lot where they're like, "You don't understand. You don't understand." And when I try to like break that down to see is that sometimes it's just age. They think because I'm younger, I don't get it because I'm not Caucasian, or I don't have the same lived experience if they're African American. If they're a veteran, I don't get it. I don't know. So, breaking that barrier and being able to even teach this intervention or provide validation and emotional support just becomes a little bit harder." - JELO*

*"I think sometimes it was difficult for me to understand their upbringing. Again, everybody is different and unique in that way, but I'm willing to learn. It's just some of their backgrounds was just so different than what I'm used to. And again, just having to reorient myself and just taking all that information into consideration when talking about how that might factor into what is happening and what they need help with at that moment. Yeah, I think that was probably one of the main gaps and challenges, because again, I want to relate as much as I can." – AMDA*

Coaches also expressed facing difficulties engaging clients due to diversity in backgrounds, values and lived experiences of clients which coaches felt unprepared to tackle. This often manifested as coaches struggling to ask the right questions to engage clients. A lack of similar values can also make it challenging for clients and coaches to connect.

*"I guess the knowledge that we have had very different experiences just living through life. So I would say, again, it's the confidence level of I'm a little bit more hesitant on my input on some topics, just knowing that what I say may be more harmful than helpful. So it's just the thought in the back of your head type thing that I don't want to cause more harm than good, essentially." – JOWA*

A few coaches reported that clients may be willing to express their problems and engage in conversations with the coach. However, they disengage when the session reaches the collection of psychometric measures such as PHQ-9 or the problem-solving component.

*"We will do the questionnaire, and we'll talk about the program and they think it's a really good idea. And then once we get down into and try to do the session and use the problem-solving treatment, I don't know, there just becomes a disconnect." - PASH*

**Theme 5:** For culturally mismatched clients initial distrust and hesitancy to engage with coach I can be effectively remedied through cultural humility, building rapport and effective interpersonal skills.

Majority of the coaches mention that cultural humility is effective in bridging any gaps during a cultural mismatch. Coaches focus on being more culturally aware, specifically about cultural differences, and recognizing cultural patterns which helps coaches effectively engage clients by asking the right questions and having a clearer perspective on how struggles of a particular culture may have shaped clients' experiences and current problems. Coaches mention clients also show an interest in coaches cultural background and client's respond well when they feel that coach is making a legitimate effort to bridge any knowledge gaps.

*"I, um, give them time to talk, I listen, I, um, am very curious about them. So I'll ask some questions about their life...I think in the listening, I'm hearing what's important to them, and I think I, I think one of the thing that maybe folks don't realize is that a lot of my clients, no one's asked them before, and no one's given them the time to listen before. So even though I might not understand this person who's sitting across from me, who's culturally different in their eyes, um, I'm not appearing as a threat, I'm very curious." – SURO*

*"When you dig a little deeper and you start to recognize these cultural patterns then you start to ask the other questions, you know, you start getting a little bit more detailed as you are building trust" – BRVA*

Effective interpersonal skills such as active listening, curiosity, empathy, patience, open mindedness and intentionality of making clients feel safe and welcomed helps clients become more trusting and engage with coach.

*"I listen to them very carefully to get as much information as I can because that I think it's important to build that rapport and the trust before they'll really open up." – CINE*

*"I think patience is key. I think rather than saying, "Well, no, I do get it, " or you can tell me, I would try to understand, I think I just continue to validate that this is where they, they are, and so I continue to actively listen and over time, they do share more and more." – LEGA*

**Theme 6:** Despite cultural mismatch, coaches often report no differences in delivering care to matched or mismatched clients, by focusing on shared humanity as a foundation to care provision.

Many coaches commented on the universality of core human experiences and how focusing on those common factors that connect coaches to clients aids in delivering PEARLS to mismatched clients. Coaches mention that all clients have similar basic needs which shift over time regardless of culture.

*"I think finding common ground is the most appropriate way for me to think of it. Focusing on the things that make us similar or the things that we share in common, rather than focusing on how we're so different." - LEGA*

*"And so I found a common ground because I understand that some of us may not be of the same color or cultural language, but maybe the same passion." – BRVA*

Several coaches also note that there are no differences in how they provide services to matched or mismatched clients.

*"I don't think that it's too much culturally different the way we're offering it. I feel like it's straight across the board." – JEKO*

Many coaches mention that their ability to provide care effectively is based on their personal motivations and values of community service, and kindness and love for older adults. Family values, positivity and respect for the value older adults bring also aids coaches in providing care.

*"Growing up I watched my parents care for other people, and so that I believe that really made my viewpoint differently to say, 'Hey, we have whatever we have, but we're going to help others and give to others. And so regardless of our lack, and so that is something that stayed with me growing up. And so it was very natural and it was a draw to me to be in a helping field." - DEDA*

*"First, I, you know, for me, it's my relationship with my Lord and Savior, but it's me just being an American first, right? And then whatever culture I'm mixed, we're all mixed up, then all those things fall in after that for me, and that keeps it simple, simpler for me. So I'm able to go in there and, and mediate and talk and advocate and be a, be a friend, be a coach, uh, with a lot of the clients that we serve." – JEPA*

*"I have a very positive outlook on my life, and I believe that that spreads over to my clients. I've always been the cheerleader for the underdog. I have a good heart. I've learned a lot. And I think because of as long as I've been alive, I've had a lot of life experiences that have helped me to be more open-minded and more understanding and to be able to stop and ask that question, "What happened? What happened? What's going on? " – PASH*

## Discussion

This study explored the experiences and perceptions of PEARLS coaches delivering care to both culturally matched and mismatched clients. It highlights the challenges and facilitators which influence care delivery while providing care cross-culturally. Study results emphasized that challenges and facilitators exist both when there is a cultural match and a cultural mismatch.

Coach-client cultural match is conducive to establishing a therapeutic relationship as coaches report that it is easier to build rapport and trust with culturally matched clients. A mixed method

study with 47 African American caregivers revealed that 83% of caregivers preferred a mental health provider who was racially and ethnically matched [31]. Consistent with this study's findings, previous literature also reports that clients who prefer a cultural match or race concordance report the importance of representation in healthcare settings, feeling more comfortable and finding it easier to build rapport with their providers. This comfort and trust may be due to shared experiences, coaches understanding of community norms, cultural values and perceived unlikelihood of discrimination [32,33].

Resonance of lived experience and feelings of kinship of coach towards client may lead to difficulty in maintaining professional boundaries especially when clients envision a more personal relationship or express overdependency on coach. A survey of Latina community health workers showed that establishing and maintaining clear boundaries was a significant challenge, which unresolved led to distress and burnout amongst healthcare workers [34]. In a qualitative study with 36 African American therapists, participants mentioned the challenges of clients wanting a more personal relationship and self-monitoring to ensure restrained self-disclosure to maintain professional boundaries. Therapists also expressed the need to be vigilant to help avoid emotional enmeshment with African American clients [35]. In a qualitative study with 16 Asian American providers, the providers expressed challenges associated with cultural match including the need for greater self-disclosure, more active involvement of providers when clients are seeking additional resources and resisting the temptation to intervene when clients experience discrimination [36]. Among the participants of this study, difficulty maintaining boundaries was more notably expressed by BIPOC providers.

Stigma remains prevalent, with several coaches using idioms of distress when discussing mental health conditions. In this study, stigma was most evident when coach and client were culturally matched. Stigma towards mental health impacts health-seeking behaviors, with likelihood of seeking care decreasing with an increase in stigma [37]. Stigma may be more prominent among culturally matched coaches due to fear of negative social judgement, possibility of stigma towards family and privacy concerns or fears of being outed when coaches belong to the same community [38]. Cultural norms often include strong shared stigma greater fear of judgement from insiders and stronger expectations for conformity [39,40].

The most notable challenge identified with cultural mismatch is the lack of shared experiences between coach and clients. This perceived lack of understanding of lived experience and historical background of client may lead to resistance of clients to engage. Furthermore, lack of understanding regarding lived experiences, values and cultural backgrounds may make it difficult for coaches to effectively engage clients. Previous studies demonstrate that clients may feel misunderstood or judged by providers on the basis of their cultural or racial background and client's may feel misunderstood if provider is unaware of their power and positionality [41,42].

This challenge can be effectively resolved through cultural humility, effective interpersonal skills and building rapport. Coaches mention interpersonal skills such as active listening, empathy, curiosity and genuine interest being effective at bridging the gap. Cultural humility acknowledges that clients have multiple intersecting identities, reinforces patients' lay expertise in their own experiences and shares powers with clients [13]. Patient-centered care requires coaches to acknowledge the diversity in experiences, perspectives and lifestyle of clients to ensure excellent care quality. Patient-centered care is essential for improving healthcare equity [44].

Despite these challenges, coaches report no major differences in delivering intervention to clients regardless of cultural match or mismatch. Coaches mention that personal motivations such as valuing community service and love for older adults and focusing on common ground helps them provide care effectively across cultures. It is important to note that while focusing on common ground to establish therapeutic relationship and deliver care is admirable, cultural nuances must not be ignored [45]. Denying cultural nuances may be highly detrimental and lead to misdiagnosis, miscommunication and erosion of trust. Cultural blindness may lead to further inequities in mental healthcare [46].

It is important to note that beyond the themes identified to answer the research questions, several coaches also talked about the effect of the current political climate on delivering PEARLS to culturally diverse clients. While some coaches mentioned that no significant changes had occurred, other contrasted this sentiment by mentioning more fear in clients belonging to racial/ethnic minorities, reduction in public assistance programs and funding issues.

These findings highlight the need for additional training and on-going support to better equip coaches to provide effective cross-cultural care. Key areas for training should include how to

practice cultural humility, how to establish clear professional boundaries, refining motivational interview skills, building rapport and recognizing cultural nuances. Coaches also expressed the desire to be further trained in supporting trauma-exposed clients, role playing to explore and prepare for difficult scenarios not covered in the base training and support for grant writing. Addressing these training gaps will ensure that coaches are providing the most excellent care possible.

### Limitations

There are several limitations to this study that must be highlighted. Participants were recruited using quota and snowball sampling, which may limit the representativeness of the perspectives shared. Individuals who agreed to participate may be unique in terms of having a greater interest in cultural nuances, cultural responsiveness and racial/ethnic minority groups. Additionally, this study focused on PEARLS, a depression intervention tailored for older adults. The findings from this study may not be transferable to other mental health interventions or client populations.

Notable strengths of this study include the use of semi-structured individual interviews for data collection and a hybrid coding approach for data analysis. Semi-structured interviews allowed the collection of rich and in-depth nuanced data regarding PEARLS coaches experiences with providing cross-cultural care [47]. Whereas hybrid coding approach was advantageous in integrating concepts identified in literature and new concepts emerging from the data [29]. This ensured that data was grounded in both existing literature and coaches' perspectives.

Future research should be focused on examining experiences, challenges and facilitators of cultural match and mismatch with coaches from the perspective of the clients. This would further aid in validating whether the findings identified by providers are also reflected in client's experiences.

## Conclusion

In conclusion, this study provides detailed insights into PEARLS coaches' experiences and perspectives on delivering care cross-culturally. These findings illustrate the need for further trainings to ensure coaches understand nuances associated with both culturally matched and mismatched clients. It is also important to note that cultural match or congruency is not inherently better than cultural mismatch, rather both have their advantages and disadvantages. It

is essential to recognize cultural differences so that care can become more culturally responsive and improve client diagnosis, treatment outcomes, quality of care, and experiences. These findings also have broader implication for supporting mental health delivery in racial and ethnic minority groups, who are more likely to experience risk factors associated with depression such as discrimination, racism, and limited access to representative care providers. Cultural responsiveness must be centered in an effort to improve health equity for all minority groups.

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