Transcultural Psychiatry for Clinical Practice

June 01, 2004 | Schizophrenia [1], Cultural Psychiatry [2], Dissociative Identity Disorder [3], Catatonic Schizophrenia [4], Major Depressive Disorder [5], Addiction [6]
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What are some of the pitfalls of treating patients from varying cultural backgrounds, what cultural issues should psychiatrists be aware of and how can they fit varying culturally based psychiatric disorders into a proper diagnostic framework? Using case studies, Dr. Moldavsky explores the clinical implications of culture in psychiatric practice.

During the last decades, along with advances in the understanding and treatment of mental illness, transcultural psychiatry has undergone a conceptual reformulation. The purpose of this review is to scan some of transcultural psychiatry's contributions to the epidemiology and clinical facts of mental disorders. I will also outline some of the main theoretical constructs of the discipline. Finally, I will deal with the place of transcultural psychiatry within the DSM.

Broadly speaking, transcultural psychiatry deals with how social and cultural factors create, determine or influence mental illness. In doing so, new and innovative treatment strategies are created. Despite influences of human and social sciences, transcultural psychiatry is rooted in medicine, especially in the biopsychosocial model. Contemporary developments such as globalization, massive migrations and the uprooting of populations (Kirmayer and Minas, 2000) put into focus questions of mental health of minorities. This has become a major focus of concern in the United States as well in other Western countries.

The Foundations
Since the inception of psychiatry as a medical science, along with innovative trends in sociology and anthropology, there was a change in transcultural psychiatry. Those changes have been extensively surveyed in two seminal papers that outlined the differences between what was termed the "new" and the "old" approaches in transcultural psychiatry (Littlewood, 1990a, 1990b). Whereas the old transcultural psychiatry focused on comparing psychiatric disorders across different cultures while maintaining the universal validity of theoretical models developed in Western countries, the new transcultural psychiatry asserts that the aforementioned models are culturally constructed and thereby only applicable mostly to Western populations. Examples that have been documented in the psychiatric literature have been those of neurasthenia and depressive disorder in China (Kleinman, 1986), or ataques de nervios in Hispanic patients in the United States (Guarnaccia et al., 1989). Today, transcultural psychiatry has a broad scope of interests, ranging from biology to the place of spirituality in mental life and disorders. Its main focuses are: cultural factors and specific psychiatric disorders; human universals (e.g., gender, age) of psychiatric disorders in different societies and cultures; culture and personality development; healing systems and social roles; culture and psychotherapy; and race and ethnicity in psychopharmacology and treatment compliance.

Basic Concepts
Disease and illness. In the context of transcultural psychiatry, disease pertains not only to the biological changes underlying behavior, but mainly to health practitioners' constructions of clinical realities according to their models. Whereas disease falls in the category of "the culture of the clinician," illness lies in a different domain. It refers to the patients' and families' recognition, labeling and experience of behavior. The importance of identifying and acknowledging the social and cultural course of disease is stressed in cross-cultural settings (Kleinman, 1988a, 1988b).

Validity and reliability. Reliability refers to the degree of consistency of observations made by different clinicians. However, validity is a more important construct for transcultural psychiatry. This has been highlighted in the literature since Kleinman (1988a, 1988b) coined the concept of category fallacy (Littlewood, 1990a). Overvaluing a construct, be it a diagnostic category, therapeutic technique or questionnaire, without testing its validity in different cultures, creates the problem of category fallacy.

Culture. This can be defined as a set of beliefs, norms and values that have symbolic value and shape the networks in which human interactions take place. The concept of cultural identity, central for the cultural formulation in the DSM, refers to the culture with which someone identifies and looks
for standards of behavior.
Some constructs relevant to psychiatry, such as self, adaptation, adjustment and bodily processes, are closely related to culture. They have not only biological meaning, but social and cultural meaning. Culture influences psychopathology through pathways like stresses, chronic social conditions (e.g., poverty, deprivation), protective factors, modulation and promotion of change, tolerance for particular behaviors, and sanction of specific idioms of distress.

Race and ethnicity. Race is a problematic construction, both from biological and sociocultural points of view. Ethnicity is the concept preferred by cross-cultural researchers. It means groups of individuals sharing a sense of common identity, ancestry, beliefs and history.

Idioms of distress. These are the ways in which people in different cultures express, experience and cope with feelings of distress. One idiom prevalent almost universally is somatization.

Clinical Topics

Psychotic disorders. The International Pilot Study of Schizophrenia, carried out in seven countries, rendered findings relevant to transcultural psychiatry despite methodological problems considered elsewhere (Littlewood, 1990a). Acute and catatonic forms of the illness were more prevalent in developing countries, whereas hebephrenic and chronic forms were more frequently seen in developed countries. Furthermore, patients from developing countries were found as having a better course of this illness (Kleinman and Good, 1985; Littlewood, 1990a). This finding was replicated by another transcultural study of schizophrenia—the Determinant of Outcome Study. These findings take into account issues such as less stigmatization in non-industrialized societies, the presence of extended family networks acting as effective support for patients and fewer societal pressures. These factors allow a more tolerant approach to sufferers and a better recovery process. Brief reactive psychoses are of interest because some behaviors, otherwise considered normal in developing countries (such as trance or other dissociative-type disorders), overlap. Those brief psychotic states are clearly influenced by sociocultural stressors—and to some extent modified by indigenous healing practices—thus opening the gate for practitioners to research alternative models of therapy (Escobar, 1995).

Depression. Major depression ranks higher for women than for men. Powerlessness and low self-esteem are closely linked to depressive conditions. These are also factors associated with severe social upheavals and major sociocultural changes (Carta et al., 2001; Kleinman and Good, 1985). Minorities, women, and immigrant and refugee populations suffer from depressive states at higher rates than the general population. The predominance of somatic symptoms in patients from developing countries is further evidence of the cultural aspects of depression (Cheung et al., 1980; Ebert and Martus, 1994; Kleinman, 1977). Conversely, feelings of guilt, a core feature of depressive cognition, are less common in these countries. It is possible that those differences are linked to the fact that in specific societies and cultures, guilt plays a less important role as a collective system of meaning (Pewzner-Apeloig, 1993).

Somatization. One of the main issues of transcultural psychiatry is the place of somatization, not only as a nosological entity, but as an idiom of distress. As such, somatization is common in all cultural and social groups (Coler and Hafner, 1991; Escobar et al., 1983). However, a certain bias in Western psychiatry exists against somatization as an inferior way of dealing with emotions and intrapsychic conflicts. Western constructions of the self emphasize independence, autonomy and expressing conflicts in psychological terms (Fabrega, 1990). However, emotions are not only psychological experiences, but sociocultural constructions as well. The cultural concept of person and self in minorities, immigrants and different ethnic groups emphasizes issues as the family group or bodily themes in the expression of distress (Pang, 1998; Yeh, 2000). The body acts as a metaphor for events of personal and social meaning (for instance, loss and grief) (Pliskin, 1992). For instance, in Hispanic groups, the syndrome of nervios as a somatized state of anxiety and depression may act as a metaphor of the social condition of this ethnic group within U.S. society (Angel and Guarnaccia, 1989; Hulme, 1996). The predominance of somatic symptoms in immigrant populations may be related to accepted patterns of access to health care (Ritsner et al., 2000). Somatic symptoms in those cases are accepted ways of expressing distress and getting help in a less stigmatic way than usual psychiatric care.

Cultural Formulation

The DSM can provide an outline for a cultural formulation of a case, with the intention of helping the clinician develop a broad sociocultural understanding (Kirmayer et al., 2003; Moldavsky, 2003). I will briefly describe the five items of this formulation, keeping in mind that it is a proposal for enhancing our awareness of aspects that are usually not fully taken into account amidst the pressures of clinical
practice. Cultural identity includes cultural reference groups, language, cultural factors in development, and involvement with culture of origin and host culture. This dimension is particularly relevant when assessing mental health and disorders in immigrant and refugee patients (Kirmayer et al., 2000).

*Cultural explanations of illness.* This includes a description of idioms of distress and local illness categories, the meaning of symptoms in relation to cultural norms, the perceived causes and explanatory models, and help-seeking strategies (Kirmayer et al., 1994).

*Cultural factors related to psychosocial environment and levels of functioning.* This deals with social supports and stressors, as well as the levels of function and disability as they are perceived within a cross-cultural setting.

*Cultural elements of the clinician-patient relationship.*

Overall cultural assessment for diagnosis and treatment.

**Clinical Vignettes**

**Case one.** "Carl" is a severely non-compliant young patient with schizophrenia. His family is gravely dysfunctional, showing an extreme level of expressed emotion. Carl's father is an observant Jew, born in Iraq but raised in Israel. His mother was born in Iran and grew up in Israel. She defined herself as "religious, but not as strict" as the father. Their interaction is marked by chronic marital discord.

The therapist focused on strengthening the relationship between Carl and his father, bearing in mind that religion could help him deal with noncompliance and rehabilitation. Furthermore, religious metaphors of experience could improve thought processes. Although Carl was in a closed ward, the therapist allowed for a couple of visits to a rabbi, who acted as a healer in the Iraqi community. The rabbi performed some healing and purification rituals.

Carl's condition improved for a short period. However, his mother complained to the medical director, disapproving of both the father and therapist. Finally, Carl's mental status deteriorated to a point warranting electroconvulsive therapy.

**Commentary.** The therapist was correct in the perception of the importance of religious metaphors in Carl's illness experience. Moreover, strengthening the attachment to the father was a legitimate therapeutic goal. However, the therapist failed to a certain extent to address both components of illness experience and disease process. Although the patient was taking antipsychotics, his mental condition was not stable when he went to the rabbi. This enabled his mother's complaints about what she perceived as an inadequate management.

In addition, the therapist failed to address the marital discord. In this particular context, a more useful approach would have been to deal with the traumatic histories of both parents, who shared traumatic experiences of uprooting and migration, as well as their different meaning of religious practices.

**Case two.** "Dara," a middle-aged woman born in Russia but living in Israel for 15 years complained of several somatic symptoms. Her husband, also born in Russia, joined her during the diagnostic interviews. The therapist himself is a grandson of Russian immigrants. He diagnosed a depressive state and started antidepressant treatment. In addition, he started supportive psychotherapy, focusing not only on the experience of migration but also on the forced adaptation to Israeli life. Both Dara and her husband were able to recover the meaning of longing for Russia. They connected with reminiscences of their past. This took place in an interactive process, in which the therapist allowed himself to relate to his origins as well. The patient remarkably improved, and the somatic symptoms abated. At the end of the therapy, the husband traveled back to Russia for the first time since their migration.

**Commentary.** Through a comprehensive assessment based on the cultural formulation model, the therapist was able to handle both the biological and sociocultural aspects of the disorder. More specifically, he focused on the experience of migration and nostalgia and enabled the couple to work through anxieties linked to questions about continuity of life. Moreover, actively engaging Dara's husband in the therapeutic process proved to be a useful strategy because she was conveying shared anxieties and symbolic meanings through her somatic idiom of distress.

**Concluding Thoughts**

To sum up the implications of transcultural psychiatry for the clinical practice, I would like to think of an approach that will incorporate the existential dimension of human suffering (Kleinman et al., 1997). However, in doing so, psychiatry must develop better treatment strategies, engage minority patients according to appropriate standards of care and fight inequalities in the health care system.
References


22. Littlewood R (1990b), The "new cross-cultural psychiatry". Br J Psychiatry 157:775-776 [comment; see comment].


