Providing Culturally Competent Care: Understanding the Context of Psychosis

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Culture—the way people make meaning and live their lives in particular social worlds—matters in psychosis. The authors explore how a patient's cultural background should influence the way clinicians think about treatment and care.

Culture—affects the risk of developing psychosis

Over the past few decades, epidemiologists have documented multiple cultural and socio-environmental risk factors for psychosis, including migration; urban living; childhood physical, sexual, and emotional abuse and adversity; ethnic density; and neighborhood social capital. Significantly heightened risk of psychosis within particular ethnic minority groups—including black minority and South Asian–origin ethnic groups in the UK and Northern Europe, and African Americans in the US—has been documented. Both first- and second-generation immigrants are at heightened risk for psychosis.¹ In general, scholars attribute the increased risk to social adversity or social defeat—the experience of being “one down” in social relationships—rather than to genetics.²

Culture shapes the course and outcome of psychosis

The striking finding that schizophrenia has a more benign course and outcome outside of the developing world has been supported by further research.³ Recently, a cross-cultural comparison of outcomes for first-episode patients treated in Montreal, Canada, and Chennai, India, found significantly improved functional outcomes and negative symptoms for the Chennai patients in spite of no differences in positive symptom severity.⁴ To be clear, some so-called treatments in the developing world are barbaric (for example, people abandoned at temples or prayer camps, harshly exorcised, or chained to trees). Nevertheless, a series of systematic studies has found that 2 years after an initial diagnosis, patients in the developing world have significantly larger periods of unimpaired functioning, and complete clinical remission is far more common.⁵ The best data come from India, and while explanations of these findings vary, greater social inclusion and access to social institutions such as marriage are likely important.

Culture also shapes course and outcome in more subtle ways. In white communities, those from non-white minority groups may be more reluctant to seek psychiatric care. When they enter care, they may experience it as more aversive. One study found that black British men were 4 times as likely as white British men to enter initial treatment involuntarily. Another study found that black...
British women had 7 to 8 times greater odds of being detained and hospitalized before outpatient treatment compared with white British women.\(^6\)\(^,\)\(^7\) Significantly heightened rates of criminal justice system interactions and/or police referrals for ethnic minority patients before initial care were also observed.

**Culture shapes the phenomenology of voice-hearing and other symptoms**

Even in clear-cut cases of psychosis, culture shapes the subjective phenomenology of psychotic symptoms. Luhrmann and colleagues,\(^8\) for example, found that compared with US subjects, patients in India and Ghana experienced their voices as less distressing, with less violent content, and as more relational. Within non-immigrant, racially homogeneous samples, culture and religious/spiritual beliefs still shape both the content and structural characteristics of psychotic symptoms.\(^9\) Barrett\(^10\) found that in a setting in which people did not regard the mind as a container, people did not understand the concept of thought-insertion. Meanwhile, socially different family expectations alter the response to psychotic experience in patterned ways. For example, traditional families in India and Mexico exhibit less “expressed emotion” than those in the UK and US.\(^11\)\(^,\)\(^12\)

Drawing on these broad epidemiological patterns and more specific detailed ethnographic research, anthropologists have identified the following 4 features that may contribute to different experiences of psychotic illness.\(^13\)

*The local cultural interpretation of mental illness.* Is the illness understood to be inevitably chronic? A broken part of the essential self? Or a passing storm? In India, psychiatrists practice what one anthropologist calls “diagnostic neutrality”: psychiatrists tend not to use diagnostic labels when discussing the illness with patients.\(^14\) Meanwhile, different meanings attached to unusual sensory experience may enable people to hold a less pathological interpretation of their symptoms.\(^15\)

*The presence of an extended family.* Is there another breadwinner? Are there other people at home to help? And is help provided, or is the person locked in a backroom and kept from inquisitive eyes to preserve the family’s honor? In India, patients stay with the family, rather than living independently. While patients may be abandoned within the family, rather than on the street, such in-family abandonment may be less harsh for the patient than abandonment on the street.\(^16\)

*Industrial age labor versus agricultural or non-wage labor.* Can the ill person work? Can he or she contribute? In a world in which wages reward performance, someone with illness will be less easy to employ. When identity depends strongly on working, as is true in US culture, the inability to work may be particularly humiliating.\(^17\) Even in the US, some communities may allow easier access to flexible or temporary work, facilitating vocational recovery, than others (eg, a rural agricultural community versus a fast-paced urban center).

*The basic social environment.* The difference in living conditions—urban squalor as opposed to the traditional family home—may ultimately be more important to outcome than any actual treatment provided. Research suggests that periodic homelessness may be near normative for US persons with schizophrenia. Americans with persistent schizophrenia often find themselves in a semi-nomadic lifestyle, cycling between homelessness, supported housing, inpatient hospitalization, and jail.\(^18\)

**CASE VIGNETTE 1**

Sita is a middle-aged housewife in Chennai. She fell ill with psychosis after the birth of her second son. Even now, 2 decades after her illness, her symptoms are severe (as judged by a standard psychiatric rating scale). Yet she has never been hospitalized for her psychosis. Her psychiatrist, husband, and father do not identify her illness as “schizophrenia” in conversation with her. They talk about her “problem.” Her parents take over for her at home when her symptoms interfere with her domestic responsibilities. While she does hear negative voices, she is more involved with her positive voices. Because she has been able to care for her 2 sons and the household, her husband sees no reason to divorce her.

**The basic commitment of culturally competent care**

These observations suggest that culture shapes psychosis in ways that are complex, subtle, and meaningful. Because of this, we hesitate to offer rule-driven guidelines for culturally appropriate clinical care (eg, with persons of such and such an ethnicity, do this and say that). Instead, we suggest that cultural competence arises from a basic attitude of humility toward patient experience along with a reflective, self-questioning awareness about the clinician’s own cultural values and culture-specific perspective on illness, symptomatology, and recovery. Consider the following 2 cases of patients who have psychosis.

**CASE VIGNETTE 2**

Michael, a disabled 56-year-old African American Vietnam veteran with a history of hospitalizations for schizophrenia, presents with persistent auditory hallucinations. He describes 2 primary voices:
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one he considers the voice of God, the other of the devil. The pastor at his church meets with him periodically and has helped him “distinguish God’s voice from the devil’s.” He reports that previous psychiatrists had dismissed his experiences out of hand.

CASE VIGNETTE 3
Umna, a 22-year-old, college-educated first-generation Pakistani-American, born and raised in the US, presents with first-episode psychosis. She describes her voices as spirits and believes that they are connected to past generations of her parents’ families in Pakistan. She expresses resistance to a biomedical explanatory framework, and she has concerns about psychotropic medications.

A culturally competent approach toward these patients might include the following:

1. Respectful, curious engagement: For patients who are either new to mental health services or have come to distrust the system, clinician respect is crucial. Open-ended questions and follow-up enable the clinician to communicate a willingness to learn from the patients—to learn their stories and to understand how their experiences of psychosis fit into their life experiences and expectations. Even gently “correcting” Umna or Michael—by, for example, alerting them to research on the neurocognitive underpinnings of psychosis—could potentially discourage further voluntary engagement and may reinforce the idea that their own explanations (grounded in religion and spirituality) are not being taken seriously.

2. Minimizing use of explicit diagnostic labels: In some settings, traditional, formal diagnostic interviews, such as the SCID (Structured Clinical Interview) or WMH-CIDI (World Mental Health–Composite Diagnostic Interview), may be unavoidable. A major downside of standard semi-structured diagnostic interviews, however, is their almost inevitable framing of unusual experiences—including experiences the patient may consider positive or spiritual in nature—as psychopathology. One way of proactively heading off any negative implications or communications is to explicitly present diagnostic interviews as imperfect but necessary for a particular pragmatic purpose (for example, to comply with billing requirements).

Such caveats may be particularly useful in working with patients like Michael and Umna, who endorse non-biomedical views of their experiences. Discussions of diagnosis should be approached with equal caution and, wherever possible, caveats about the significance of such labels. (Bear in mind that the official summary report of the DSM-5 psychotic disorders committee described categorical diagnoses such as schizophrenia as imperfect and provisional. 19)

Creating a collaborative, culturally competent treatment plan
Increasingly, evidence-based psychotherapeutic approaches to psychosis emphasize the shared exploration of the patient’s symptoms with the development of common goals. For Michael, that discussion would include the role that pastors have played in helping him navigate his experiences and might even involve a pastor in treatment.

Conversations with Umna revealed that her concern was not with medication per se, but with drugs framed as targeting a “brain-based illness.” When the clinician supported Umna’s interest in holistic (mind-body) interventions like acupuncture and yoga, Umna expressed much more openness to the role that antipsychotics might play in helping her navigate her experiences.

Consider direct engagement with voices
New evidence-based psychotherapeutic approaches also emphasize engaging with voices—at the minimum, exploring the meaning such voices have for those who hear them. New therapeutic approaches (cognitive behavioral therapy for psychosis, acceptance and commitment therapy for psychosis, avatar therapy, hearing voices movement groups) present ways to work with voices with the expectation that patients can negotiate a different, more positive, relationship with their voices. Such approaches stand in clear contrast to older assumptions that extended exploration of a patient’s psychopathology risks symptom exacerbation. New approaches also suggest a pragmatic focus on addressing distress rather than assuming that all symptoms should be targeted and ideally eliminated—regardless of how the patient views them.20

Final thoughts
Psychiatric care is itself part of the cultural context that shapes the experience of the person with psychosis. We each live within what Jerome Frank called an “assumptive world.” Culturally competent care means remaining aware that one’s assumptive world is not necessarily shared by others and has only a limited grasp of the world as it is.

Our Most Troubling Madness, a recently published book on culture and schizophrenia, presents 12 case studies of schizophrenia in Western and non-Western countries with an in-depth review of
ethnographic and epidemiological findings for those who wish to pursue these questions further.\footnote{13}

**Disclosures:**
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