Role of Culture in Psychiatric Evaluation and Management

R.C. Jiloha*, Manish Kandpal**, Soumya Mudgal***

*Director Professor & Head, **Assistant Professor, ***Senior Resident
Department of Psychiatry, G.B. Pant Hospital & Maulana Azad Medical College, New Delhi, India

Abstract: Culture is a set of norms, values, beliefs, traditions, customs, history and folklore, shared by a group of people. Culture plays a complex role in the natural history and psycho-social development of human behaviour. The interaction between culture and its components with clinical phenomenon and psychiatric evaluation and management is broad and multi-faceted. Culture plays an important role in evaluation and management of psychiatric cases but at present the cultural factors are poorly used in psychiatric evaluation. The present paper evaluates and emphasizes the role of cultural factors in psychiatric illnesses.

Keyword: Culture bound syndromes; Social norms; Mores; Cultural Psychiatry

CULTURAL FACTORS IN PSYCHIATRIC EVALUATION AND MANAGEMENT

It is essential for the clinician to understand patient’s cultural background. Clinician should identify, recognize and evaluate the impact of culture on mental health. Culture plays an important role in the evaluation process. Cultural factors may have a powerful pathogenic impact as triggers of psychopathology e.g., the role of ghost affliction or supernatural powers in Indian culture and violence in television shows in the development of violent behavior among predisposed children or adolescents. They can also contribute to higher or lower levels of severity of psychiatric symptoms e.g., delayed help-seeking response to the appearance of acute psychotic symptoms in a family member. They can be agents in the expression of clinical symptoms, reflecting the dominant themes of the historical period in which the illness occurs. They are certainly decisive elements in treatment seeking and choice of the therapist.

At present, culture is poorly used in psychiatric evaluation. Culture in clinical assessments is limited to mentions of race, ethnicity, language or migrant status. Culture is too complex in content and too heterogeneous in nature to be covered by relatively simple clinical interactions. Literature contributions dealing with culture in clinical practice and diagnosis are mostly descriptive, narrative, and/or colored by sociological, anthropological or even ecological viewpoints, therefore labeled and dismissed as “soft science” by clinicians and scientists. Many believe cultural factors to be important only for treatment and management issues, perhaps preventive measures, but not for diagnosis per se.

Culture-bound syndromes are uniquely related to specific cultural characteristics of the human groups in which they occur; as such, their etiological, pathogenic and clinical manifestations do not correspond to the conventional entities included in mostly Western based nomenclatures. Culture-bound syndromes have, indeed, a venerable history enriched by contributions of notable clinicians and researchers in the last four or five decades. A partial list of culture-bound syndromes was included in the Appendix I of DSM-IV, but it did not do justice to the extensive literature on the topic. Practically every region of the world has a set of culture-bound syndromes but the question is, are they nosologically autonomous entities, or do they have enough similarities with existing clinical conditions currently listed in DSM or ICD?

CULTURAL COMPONENTS IN PSYCHIATRIC EVALUATION AND MANAGEMENT

The cultural components of psychiatric evaluation cover a variety of areas. The following are the main aspects about which information must be gathered in the process of a well-structured clinical interview.
CULTURAL VARIABLES

Cultural variables such as language, religion and spirituality, gender and sexual orientation, traditions and beliefs, migration history and level of acculturation should be covered in the initial phase of a clinical evaluation. In traditional Indian society, the patient and the general population often reposes great trust on the treating doctor. The patient often comes with the notion that the doctor knows the best and expects the doctor to make a decision about the treatment. A paternalistic view had been the norm over a long period, though the trends are changing now 38. Confidentiality is another culture-specific issue. Patients are often accompanied by family members, who would often be present while clinical history is taken and examination is conducted. The patients often may not object to the family members being told about the medical details. Many times, the information shared may be of sensitive nature, where it may not be in interest of the patient to share the information 39,40.

FAMILY DATA

Family is another cultural variable to deserve a special focus. Family history, structure and life provide data about what are called “microcultural” or “micro-environmental” segments in the patient’s history. Areas such as raising modalities, roles and/or hierarchies, valueinfusing activities, eating habits, status of women in the family, religious beliefs and moral values and social interactions (e.g., community celebrations) must be inquired about, as part of the whole assessment process. Help-seeking patterns, may not be a strictly a diagnostic component, represent a great deal of family attitude about interactions with the outside world in general, and the health professions in particular 41.

PATHOGENIC AND PATHOPLASTIC FACTORS

The environment (or “macro-environment”) is a source of both preventive) and harmful factors in the development of any clinical condition. The identification of environmental pathogenic factors is essential. Such factors include family life, the impact of agencies such as media, socio-political structures, rules and values of public behavior, rituals, and the like. Pathoplastic factors refer to the uniqueness of symptom expression. The clinician should recognize the description of the symptoms by patient and relatives, the words and terms used, and the context in which the clinical story evolves. Environments shape the form of the symptoms: e.g. a delusion is identified in the psychopathological assessment, now and ever since clinical psychiatry became an established discipline; the delusion’s content, however, will be different in a 21st century patient growing up in an urban, technologically-dominated world from that of a patient from 200 years ago, living in a predominantly rural, much less complicated environment. The distinction between the appearance of the symptom, its verbal description, and the patient’s surrounding reality are the key elements of the evaluation.

EXPLANATORY MODELS

One way of examining the role of culture in psychiatric disorders it to elic the explanatory models of traditional healers26-28. Explanatory models offer the idiosyncratic perspective of patient and relatives about the origin (cultural etiology?) of the symptoms, why they occur, and how the process of “getting ill” has evolved (cultural pathogenesis?). This approach is based on the notion that reality is socially constructed. An explanatory model (EM) is defined by Kleinman 1984 as the “notions about an episode of sickness and its treatment that reality is socially constructed. An explanatory model (EM) is defined by Kleinman 1984 as the “notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process”29. The exploration could expand into why has the particular patient become the “target” of such symptoms, and what should be done to overcome them30. Culture plays an important role in treatment seeking behaviour. In the traditional Indian society a great majority of patients reach the modern mental health services via faith healers.

In their community belief, every body knows that the commonest cause of illness is the invasion of the sick person’s body by a supernatural power: this may be the action of a witch, a ghost, or the anger of a god. A healer, in the people’s view, is one who himself has the magical power to exorcize them. For them, modern treatment is incomplete without advice on certain dietary recommendations31. While studying “Explanatory models of mental disorders among traditional healers and their patients in rural south India” it was found that an understanding of local patient perspectives of mental disorders will allow modern medicine to provide culturally sensitive and locally acceptable health care32. Stigma of mental illness in the Indian culture leads to social distance, rejection, guilt and responsibility for illness and influences the treatment seeking behavior33. The cultural stamp of these explanations should not be underestimated, as the information is valuable and relevant for both the diagnosis itself, and for aspects of the eventual multidisciplinary (multi-conceptual or multi-dimensional) management process. These models are linked to particular categories of illness and reveal labels and cultural idioms for expressing the experience of illness.

PATIENT’S STRENGTHS AND WEAKNESSES

The mental status examination, part of a clinical history includes now a section outlining the individual patient’s strengths and weaknesses as reported by him/her and/or by family members. The cultural nature of this piece of information is undeniable: being the product of self-observation, it reflects issues of self-image and subsequent self-esteem, interaction styles, social disposition and skills, level of performance, even subtly disguised yearnings for change, or clear therapeutic targets.50 Furthermore, strengths and weaknesses (the latter considered barriers against treatment approaches) configure what is known as “coping styles” of the patient vis-à-vis the adverse events originating, leading to, or aggravating the pathological symptoms. Culture plays an important role both in evaluation and management of a psychiatric case in the following way:

1. Conception of the etiology of mental illness: It has been documented in the literature that certain ethnic groups relate the origin of mental illnesses to spiritual or religious factors 51,52. Psychiartists must be aware of this possibility and, thus, recognize and respect it during the evaluation and treatment of patients from different ethnic and cultural groups.

2. Manifestation of symptoms may vary from culture to culture: Hispanic American and Indian patients very frequently manifest their anxiety and symptoms of depression through somatization 52-53. Therefore, somatic complaints must be understood and integrated as part of these psychiatric conditions, particularly when no objective organic reasons that could explain this type of symptoms are present.

3. Treatment compliance is influenced by one’s culture: Cultural factors tend to be found at the core of the problem of treatment compliance 57-59. Therefore, psychiatrists need to understand not only the concept of “disease” as a pathophysiological phenomenon but the concept of “illness” as well, with its host and environment connotations.60-61. Compliance in the psychiatric setting depends primarily on the doctor-patient relationship and, above all, on the therapeutic alliance; cultural factors play a unique role in the development of both.

4. Need to integrate psychiatric care with religious institutions: The treating psychiatrist should be knowledgeable about and sensitive to the main aspects of the patient’s culture.62-63 Success of any treatment in psychiatric disorders calls for due recognition of cultural factors both in evaluation and management.

REFERENCES


