Clinical management of patients across cultures

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Clinical management of patients across cultures challenges the clinician's familiar tried and tested strategies. The relationship between the patient and the psychiatrist is often examined in isolation from a number of premises which both patient and professional bring to the encounter: previous experience of other cultures, contact with less familiar cultures, past experiences and socio-economic status are some of the determinant influences. There are a number of ways in which the clinician can facilitate therapeutic effectiveness. However, a trusting relationship must first emerge such that the patient has faith in the treatment recommendations. Special difficulties can arise in the context of pharmacological, social, psycho-therapeutic and psychological interventions. Community, out-patient, in-patient and emergency settings each require that consideration be given to the context of the assessment and treatment process, as well as the content and immediate outcome. The clinician must plan the assessment and intervention carefully. The rationale and goals of treatment should be discussed and agreed by participants in the therapeutic interaction. Special groups have unique cultural and historical obstacles to receiving health care. Potential problems are highlighted in this paper and suggestions made for managing conflicts when they arise.

Psychiatry across cultures

Britain is a multi-cultural society. The needs of patients from other cultures are becoming paramount in the planning and delivery of psychiatric services. In our previous paper we highlighted some of the problems that psychiatrists may come across in the process of assessment (Bhugra & Bhui, 1997); here we will focus on the clinical management of patients from other cultures.

Distress among migrant communities can be understood in terms of common migration-related themes; yet migrant communities are hetero-geneous in the cause of their problems and in their personalised models of illness, as well as in their appraisal of who in society can act as a help-giver. This diversity is further amplified by the evolving culture of the younger generation. Britain's Black communities regard the UK as their home and do not see themselves as immigrants; the use of migration-related models of cross-cultural assess-ment and management is now less often of help. Psychiatrists generally take account of socio-cultural factors in the aetiology and management of psychiatric problems; however, less attention has been directed to those groups who suffer disadvantaged access to health care because of societal values and beliefs and the structure of the health care system. Despite a general awareness of social and cultural issues, the active engagement of cultural aspects of our patients' presentation is often set aside for pragmatic reasons to do with time and manpower. The primary goals of this paper are to set down some principles for planning treatment and to place physical and psychological therapies in a culturally syntonic context.

Principles of management

Clinical management of psychiatric problems is determined by data obtained within the context

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of professional–patient interaction. Such a meeting can take place at community, out-patient and in-patient levels. Each of these levels will influence the consultation in terms of degree of crisis, source of referral, immediate resources available to the clinician, the amount of observation data available, and the patient's level of distress or unfamiliarity with the environment. The context of consultations is often not considered but may crucially influence the quality and completeness of the information obtained. Kleinman's (1977, 1988) concepts of category fallacy (making conditions defined by other cultures 'fit' into Western models of diagnosis), idioms of distress (patient expressing subjective concerns with culturally mediated meanings) and explanatory models are worthy of consideration in every therapeutic encounter. Furthermore, the health professional is usually one of many individuals that the patient has 'consulted' in order to return to their previous level of functioning. This is true of members of both majority and minority cultures. The clinician must make every reasonable attempt to understand individual patients' and their families' models of causation of illness and management

Goals of treatment

Patients are interested in finding out what they should do to alleviate their distress. The purpose of the assessment is to determine not only the explanatory models and idioms of distress, but also to allow shared treatment goals to be identified. Acculturation has been understood largely as a process experienced by the first generation of migrants, whereas their children may well have to face a different type of socio-cultural conflict. Hence the treatment options and goals may be differentially received by different generations. In a multi-cultural society broad societal pressures, narrower familial expectations, different 'help-seeking motivations', styles of making sense of the world and dealing with the world all require an integrated individual appraisal. The goals of treatment under such conditions may be broader and may incorporate social interventions to a greater extent than is usual; especially so where there are spiritual or religious objections to medication. Well-intentioned but amateurish, non-indicated or poorly timed interventions may precipitate or even exacerbate psychopathology. For example, if compliance becomes a focus of conflict, it could harm an effective treatment alliance and ultimately result in an exacerbation of symptoms. Any therapeutic efforts need to be sensitive to the unique scenario presented by the patient.

Planning treatment

The basic treatment planning for patients from other cultures is no different from planning for patients who share a greater amount of their cultural attributes with the clinician. However, additional factors to do with language, training, social and cultural rehabilitation and cultural conflicts will need to be taken into account. For patients from other cultures, the multi-disciplinary team will often require all of its mix of skills; indeed, it may have to evolve new strategies in order to plan an appropriate treatment package. If language is a problem and bilingual workers are not available, other familiar and trusted (by the patient) community members could be involved. Of course, interpretation, if required, should ideally avoid using a member of the patient's social group. The whole process will take longer and becomes more complex, not least of all in relation to patient confidentiality. Treatment planning may only be viable with the active consent and involvement of members of the family who could facilitate or impede the clinician's desired pace of progress. The contemporary strength of family ties, expectations and aspirations will all be important. When caught between cultures, the kinship ties of a cultural group may well change according to the local customs and with the passage of time. Clinicians should avoid deploying their own kinship/family systems as normative. Careful scrutiny of local customs and culture is required; such knowledge should be easily accessible from the families themselves as well as other members of the patient's community. Health professionals ascribed the same ethnicity as a patient may share little with that patient's culture; hence merely seeking an ethnic match is likely to be inadequate if other aspects of culture are not also considered. Unfortunately, clarification of what an individual's cultural expectations are is likely to take some time and may not be readily achieved in a single, convenient assessment.

Physical treatments

Physical treatment, such as drug treatments and ECT, carry different symbolic representations according to past experience and culture. Where the models of illness include physical causation and physical treatment to alleviate such conditions, the problems of compliance may not be as visible an issue but attention to drug dosages and side-

effects may well become the factors upon which the patient decides to accept or refuse treatment.

Pharmacotherapy

Using pharmacological agents as a first line of management for severe mental illness is a common practice. However, the doses prescribed are often those recommended generally, regardless of ethnic group. Pharmacokinetics vary across race and culture; a drug may be absorbed, distributed through the body, localised in tissues, metabolised and excreted at different rates across different groups. Age, gender, race, diet (ingestion of coffee, use of nicotine, etc.) have all been shown to affect levels of drugs in the body. The role of diet is under-evaluated in clinical therapeutics (although heavy smokers may need higher doses of neuroleptics and antidepressants). Westermeyer (1989) points out that those from developing regions may well possess models of drug treatment in accord with their use of aspirin, penicillin or herbal medicine. Here the individual expects a quick response with minimal dosage for a minimal period. Such a conceptualisation of pharmacotherapy will encourage expectations of a rapid response, if not within a few hours then at least a few days, rather than the weeks that neuroleptics or antidepressants may take. If such relief is not forthcoming, patients could discontinue the medication, ask for a different medication or use other medicines in conjunction to obtain such relief. A protracted period without relief, side-effects, dietary restrictions and the way in which psychotropics are prescribed will all lead the patients and their families to view such interventions as problematic unless careful explanation is given with an emphasis on checking that the necessary information has been received in an undistorted form (see Box 1).

Neuroleptics

Pharmacokinetic studies have shown cross-racial differences in neuroleptics. Using normal Asian (Japanese, Korean and Chinese Americans) and Caucasian volunteers and administering halo-peridol to them, Asians have been found to have significantly higher serum levels and a more pronounced prolactin response compared with the Caucasian group. Also, 95% of Asians (Japanese, Korean and Chinese American) treated with haloperidol developed extrapyramidal side-effects within their first two weeks, whereas only 60% of Black patients and 67% of Whites did so in the same period. Black in-patients, on the other hand,

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Box 1. Implementing a pharmacotherapy plan

Clarify the symptoms and diagnosis and indications with the patient and family
Provide written and oral information on the dosage, side-effects, interactions with other substances (especially foods, herbs)
Start at low dosages and keep a close watch on side-effects
Involve a family member to act as 'co-therapist'
Inform the patient of key side-effects and enable them to access the team or their GP in emergencies
Be aware of cultural patterns which may affect compliance

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have shown higher blood levels per milligram dose of chlorpromazine compared with White in-patients (see Lin *et al*, 1995).

Antidepressants

Caucasians appear to have lower plasma levels of tricyclic antidepressants (TCAs) and attain plasma peaks later compared with Asians (Japanese, Chinese, Korean and those from the Indian sub-continent). These differences are said to be due to a greater incidence of slow hydroxylation among Asians. The evidence of ethnic differences in pharmacokinetics of TCAs remains inconsistent. Overall, the data suggest that dosages of anti-depressants should be carefully individualised over a prolonged period, especially for Asian and African–Caribbean patients.

Lithium

Lithium has been shown to be effective at lower serum levels among Japanese people (Takahashi, 1979; Okuma, 1981). Racial differences in red blood cell sodium and lithium levels have been recognised for some time. Patients in Taiwan (good responders) have lithium levels 0.5–0.79 mmol/l, whereas in Hong Kong these levels are, on average, 0.63 mmol/l. Chinese patients respond to levels around 0.71–0.73 mmol/l, which is lower than the Caucasian sample levels of 0.8–1.2 mmol/l. The precise significance of such pharmacokinetic differences is uncertain.

Culture, diet and pharmacotherapy

Dietary patterns are influenced by the availability of certain kinds of food as well as religious and

social taboos. The role of diet has been clearly understood in relation to some psychotropic drugs such as monoamine oxidase inhibitors (MAOIs). In cultures where humoural concepts of hot and cold food are well described, the patients will often see drugs as hot and ask for food prohibitions or additions which may contribute to cooling of the excess heat produced by the drugs. It is also likely that some traditional medicines and foods may have ingredients which interact with prescribed psychotropic medication.

Ethanol metabolism varies tremendously across ethnic groups and the use of alcohol with prescribed medication may well produce side-effects which are difficult to understand and manage. Additional factors theoretically operating on pharmacokinetics might include food additives, use of over-the-counter medication, herbal medication, and air pollution (Westermeyer, 1989).

ECT

There is some evidence that African–Caribbeans in the UK are given ECT more frequently, even though they are more likely to be diagnosed as suffering from schizophrenia. This discrepancy remains hard to explain. The underlying indications for ECT remain the same whatever the ethnic group. However, additional problems in ethnic minority patients are to do with the fear and the stigma of ECT – and victims of discrimination and persecution may symbolically invest ECT as a further threat. Any approach to the patients, therefore, must be gentle and must include their relatives and families in a full and frank discussion. Reading and audio-visual materials, wherever available, will make it possible for ECT to be actively considered by patients in an informed way. Meetings can be arranged between the patients, their families and patients who may have received ECT (along with the recovered patient's family) and thus the extreme fear of ECT may be reduced (Westermeyer, 1989).

Complementary therapies

There are two groups of treatment that the clinicians need to be aware of. First, patients and their families may urge the clinician to offer alternative therapies like acupuncture, reflexology, aromatherapy, etc. Second, the patient may be taking unprescribed medication – herbs or other substances from culturally embedded healing practitioners such as Hakims, Vaids and Unani physicians. Acupuncture may appeal to the patients and the service planners as meeting patient need, but in the long term it may not prove to do so because it is unlikely to effect a cure for a chronic condition. Temporary systematic relief, if evident, may still not be seen as sufficient reason for delivering such interventions when the financial implications are considered. Yet, in some individuals such an investment may be the only intervention which affords symptomatic relief and could form a part of a carefully considered treatment package. Professionals have not established clearly whether acupuncture or any other complementary treatments have a role to play in the relief of depression, anxiety or persistent psychotic symptoms.

Culture, therapy and personality

Murphy (1969, 1972) argued that not only do individual personality traits play an important role in responses, but also these traits are modified by culture. When culture allows and encourages individuals to be independent, to struggle and take action, there may be a greater readiness to use and hence need medication. On the other hand, where culture encourages individuals to be inter-dependent and to take healing decisions and actions by group process, less emphasis will be given to medication. Personality traits have been linked with pharmacodynamic as well as pharmacokinetic properties. The prognostic value of subjective responses needs to be investigated more thoroughly.

Psychotherapy

Provision of psychological treatments for individuals from other cultures brings with it its own problems in that apart from the language – verbal and conceptual – some cultures may find the Western concepts of ego-dependent psychology inappropriate and threatening. In cultures where the individual self remains an integral part of the society and family, individual psychotherapy will not be easily acceptable. In addition, group therapies may well create difficulties, and issues to do with confidentiality remain of great concern to individuals.

The quality of the therapy offered, especially if patients do not understand the rationale and have low expectations of it, may play a very important role in the acceptance of therapy (Balabil & Dolan, 1992). Service providers have to know the community's attitudes to the processes of healing

when planning to provide psychotherapy services (see Bhugra, 1993). Potential referrers should be especially curious about an individual's expectations and perceptions of 'talking treatments' and ensure that the barriers to such treatment being realised are not located within the faulty appraisal of potential on the part of the professional.

Racial and social oppression will determine the type and intensity of psychopathology, as well as the ability of an individual to share their emotional states with help-providers.

Tyler *et al* (1991) suggests that one of the major problems in psychotherapy is that of universalistic perspective. This is a congruent process where the therapist aims to capture the commonality of experience between himself/herself and the patient. Conversely, the particularistic view argues that ethnic, racial and cultural variables significantly shape the world view of both the therapist and the patient; hence, any such therapy needs to focus on racial and ethnic issues and especially with ethnic matching of the therapist and the patient (see below). Alternatively, ethnic, racial and cultural values can be transcended in therapy; the focus is then on the skill and experience of the therapist, rather than ethnicity *per se*.

Specific models of psychotherapy

Each model brings with it a rationale in which the patient and therapist must believe for the encounter to be effective. From the psychoanalytic body of knowledge the concepts of ego, id and superego have entered common parlance as have oedipal complex and the management of "arrest" at each stage of oral, anal or genital experiences. Often, practitioners in other cultures have borrowed concepts without necessarily looking at the cultural relevance of such concepts. The transference-countertransference dyad, lying at the core of psychoanalytic therapy, produces a unique set of problems when the patient and the therapist have different ethnic and racial identities. Countertransference has to be seen as an experience affected by the individual's cultural knowledge and experiences.

Behavioural therapies can work across cultures, especially because behavioural tasks are observable and measurable and the individuals may respond to these tasks very well. The principles of engagement in a behavioural enterprise may require modification, perhaps with much greater emphasis on explanation. The potential for breaches in the treatment alliance arise from the same sources as in other models of therapy.

McCarthy (1988) observes that any attempts to modify behaviour in the direction of the therapist's norms may be deeply offensive and threatening to the patient, and the therapist may risk being offended by culturally determined stereotypes which may clash with his/her beliefs. Attempts to use social skills assessment, assertiveness training, dating behaviour, attitudes to specific problems, and perceived causation of these problems are doomed to failure and increase the discord between the patient and the therapist if these are not handled in an appropriately sensitive manner. Behavioural therapy is focused, needs limited interpreter time, can be used easily to assess improvement and is not seen as a threat but is congenial to certain religious philosophies.

Cognitive techniques have become a valued part of the armamentarium against depression. However, cognitive models of depression have not been validated across cultures.

Westermeyer (1989) highlights social therapies as including family therapy, group work, social network reconstruction, acculturation therapy and resocialisation processes. One underlying premise of all these therapies is the identification of life areas (such as language, occupational skills, family life) and then linking these with specific goals and activities depending upon individual needs. Mutual support and help groups, art therapies, groups with religious leanings and readings can be set up. These may be seen as non-threatening and hence more acceptable. The relationships within such settings allow both the therapist and the patient to progress towards a mutually agreed and acceptable goal at a pace which is non-threatening to both parties. In addition, such approaches work as two-way processes for educating the therapist as well as the patient.

Indigenous therapies

In Puerto Rican children in New York, Cuento therapy has been used. This uses folk tales from Puerto Rico to present models of adaptive behaviour, and has been tailored to the bi-cultural conflict experienced by Puerto Rican children; results included a clearly marked reduction in anxiety persisting at one-year follow-up (Constantino *et al*, 1986).

Similarly, using religious models in therapy with patients in India has led to development of theories which put the patient's dilemmas in a socio-religious context, thereby encouraging the individual to seek out appropriate solutions (for review see Lloyd & Bhugra, 1993). Singh & Oberhummer (1980) successfully used a combination

of behavioural therapy and karma yoga to treat an Indian female presenting with obsessive ruminations.

For some ethnic groups, the therapist needs to be assertive and directive. In Hindu and Buddhist philosophies, a merging of the self with general fate, mastering of personal ambition and honouring the rights of care and duty to others are essential components of living, and the therapist will need to take all of these into account while planning any psychotherapeutic interventions. Using Vedic rituals for managing addiction and yogic methods for managing anxieties and stress are related to developing indigenous models which often go on to have a universal appeal.

Ethnic matching

Ethnic matching of the therapist and the patient is not essential. Several studies have indicated that the patient's first experience of the therapist and the skill and overall experience of the therapist are more important than their ethnic identity. As discussed above, rather than focus on the particular school of therapy, the individual therapist needs to transcend the interaction and be able to deal with the patient's problem in a sensitive manner. Ethnic matching is often advocated on the basis that this will allow the patient to be freer in highlighting his or her problem, but the reality is that the therapist is still seen as 'one of them' and as being middle-class, thereby emphasising the class differences (see Box 2).

Management and service development

Strategies to do with the management of individual patients have been outlined. We wish here to draw attention to the larger population perspective of ethnic minority communities. Although individual management is surely likely to be the most important point of contact between patient and professional, there are inevitable organisational barriers which will make the optimal implementation of the above strategies difficult and in some instances impossible in view of resource limitations. However, this reality highlights the need for each service to build an infrastructure of services, personnel and expertise, which can flexibly respond to an evolving community's demographics. Furthermore, in a rapidly evolving

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> **Box 2. Methods of confrontation without threat**
>
> Be aware of the meaning of conflict according to the patient's reference group
> Pose the confrontation as classification
> Diffuse the transference among staff members
> Establish trust and support before confrontation
> Identify the purpose of confrontation and its potential value
> Identify confrontation within the cultural context without challenging religious taboos
> Facilitate confrontation after discussion with family and peers

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mental health service there remain a number of crucial re-organisational imperatives which are likely to 'trump' the needs of a particular group. Such processes need to be openly examined and the organisations need openly to state their specific position managerially on service provision for ethnic minorities. It may be a reality, for example, that certain desirable service structures or staff positions cannot be created for fiscal reasons. This again should not deter the overall aim of better service provision for all communities, but once budgetary priorities are openly acknowledged a plan of implementation of immediate, medium-term and long-term service changes can then proceed. Training and the generation of expertise about the communities of relevance to each health team should be integral to overall management. Only then will whole communities gain a greater level of trust in the ability of a system of health care, which to many ethnic minorities remains aversive and to be used only at times of crisis.

Conclusions

The clinical management of patients from other cultural groups relies on the individual therapist's skill, experience and training. Using appropriate models of therapy allows the therapist–patient interaction to work at a level at which both participants feel comfortable and are able to work with each other. Within such an interaction, physical therapies need to be tailored according

to ethnic group as well as clinical needs. Psycho-analytic psychotherapies may well work in some situations, but behavioural and cognitive therapies may be seen as more appropriate and acceptable. In planning any treatment, the involvement of the family and understanding of community norms will allow the therapist to provide culturally sensitive and appropriate therapies whenever and wherever needed.

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Multiple choice questions

1. Therapeutic interaction depends upon:
   a the patient's social class
   b the patient's knowledge of English
   c the doctor's knowledge of medical models
   d the emotional language
   e the patient's expectation of treatment.

2. Pharmacological treatments:
   a are always the first line of management for severe mental illness
   b suggest same doses of neuroleptics across ethnic groups
   c must take into account effects of nicotine and coffee intake
   d must be started after giving adequate information
   e should include regular monitoring of side-effects.

3. In planning treatment:
   a rapport has no role to play
   b educating the patient and family is a waste of time
   c enquiries must be made to find about self-medication
   d the patient's previous experiences may have a role to play
   e the stigma of mental illness must be taken into account.

4. Psychotherapy across cultures:
   a can work only if the patient and the therapist come from the same culture
   b must include psychoanalaysis
   c must be modified appropriately
   d does not work
   e always involves families.

5. In psychotherapy:
   a indigenous components make the therapy more acceptable
   b religious values may give a useful overview
   c behavioural techniques may be seen as demeaning in some cultures
   d recent migrants may describe symptoms of loss
   e use of language interpreters is contraindicated.

MCQ answers				
1	2	3	4	5
a T	a F	a F	a F	a T
b F	b F	b F	b F	b T
c T	c T	c T	c T	c T
d T	d T	d T	d F	d T
e T	e T	e T	e F	e F