02 - 3.2 Transcultural Psychiatry

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machine, whose purpose is optimal adaptation to the perceived environment. Lacking sufficient information, the machine cannot form a cognitive map against which current experience is matched. Disorganization and maladaptation then result. To monitor their own behavior and to attain optimal responsiveness, persons must receive continuous feedback; otherwise, they are forced to project outward idiosyncratic themes that have little relation to reality. This situation is similar to that of many psychotic patients. Physiological Theories The maintenance of optimal conscious awareness and accurate reality testing depends on a necessary state of alertness. This alert state, in turn, depends on a constant stream of changing stimuli from the external world, mediated through the ascending reticular activating system in the brainstem. In the absence or impairment of such a stream, as occurs in sensory deprivation, alertness drops away, direct contact with the outside world diminishes, and impulses from the inner body and the central nervous system may gain prominence. For example, idioretinal phenomena, inner ear noise, and somatic illusions may take on a hallucinatory character. REFERENCES Burghardt GM. Darwin’s legacy to comparative psychology and ethology. Am Psychologist. 2009; 64(2):102. Burt A, Trivers R. Genes in Conflict: The Biology of Selfish Genetic Elements. Cambridge, MA: Belknap Press; 2006. Confer JC, Easton JA, Fleischman DS, Goetz CD, Lewis DMG, Perilloux C, Buss DM. Evolutionary psychology: Controversies, questions, prospects, and limitations. Am Psychologist. 2010;65(2):110. De Block A, Adriaens PR. Maladapting Minds: Philosophy, Psychiatry, and Evolutionary Theory. New York: Oxford University Press; 2011. Griffith JL. Neuroscience and humanistic psychiatry: a residency curriculum. Acad Psychiatry. 2014;1–8. Keller MC, Miller G. Resolving the paradox of common, harmful, heritable mental disorders: Which evolutionary genetic models work best? Behav Brain Sci. 2006;29(4):385–405. Lipton JE, Barash DP. Sociobiology and psychiatry. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 9th ed. Vol. 1. Philadelphia: Lippincott Williams & Wilkins; 2009:716. Millon T. Classifying personality disorders: An evolution-based alternative to an evidence-based approach. J Personality Disord. 2011;25(3):279. van der Horst FCP, Kagan J. John Bowlby - From Psychoanalysis to Ethology: Unravelling the Roots of Attachment Theory. Hoboken: John Wiley & Sons, Inc; 2011. 3.2 Transcultural Psychiatry Culture is defined as a set of meanings, norms, beliefs, values, and behavior patterns shared by a group of people. These values include social relationships, language, nonverbal expression of thoughts and emotions, moral and religious beliefs, rituals, technology, and economic beliefs and practices, among other items. Culture has six essential components: (1)

Culture is learned; (2) culture can be passed on from one generation to the next; (3) culture involves a set of meanings in which words, behaviors,

events, and symbols have meanings agreed upon by the cultural group; (4) culture acts as a template to shape and orient future behaviors and perspectives within and between generations, and to take account of novel situations encountered by the group; (5) culture exists in a constant state of change; and (6) culture includes patterns of both subjective and objective components of human behavior. In addition, culture shapes which and how psychiatric symptoms are expressed; culture influences the meanings that are given to symptoms; and culture affects the interaction between the patient and the health care system, as well as between the patient and the physician and other clinicians with whom the patient and family interact. Race is a concept, the scientific validity of which is now considered highly questionable, by which human beings are grouped primarily by physiognomy. Its effect on individuals and groups, however, is considerable, due to its reference to physical, biological, and genetic underpinnings, and because of the intensely emotional meanings and responses it generates. Ethnicity refers to the subjective sense of belonging to a group of people with a common national or regional origin and shared beliefs, values, and practices, including religion. It is part of every person's identity and self-image. CULTURAL FORMULATION Culture plays a role in all aspects of mental health and mental illness; therefore, a cultural assessment should be a component of every complete psychiatric assessment. The outline for cultural formulation found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is intended to give clinicians a framework for assessing the role of culture in psychiatric illness. Its purposes are (1) to enhance the application of diagnostic criteria in multicultural environments; (2) cultural conceptualizations of distress; (3) psychosocial stressors and cultural features of vulnerability and resilience; (4) to enable the clinician to systematically describe the patient's cultural and social reference groups and their relevance to clinical care; and (5) to identify the effect that cultural differences may have on the relationship between the patient and family and the treating clinician, as well as how such cultural differences affect the course and the outcome of treatment provided. The outline for cultural formulation consists of five areas of assessment: (1) cultural identity of the individual; (2) cultural explanations of the individual's illness; (3) cultural factors related to psychosocial environment and levels of functioning; (4) cultural elements of the relationship between the individual and the clinician; and (5) overall cultural assessment for diagnosis and care. Cultural Identity of the Individual Cultural identity refers to the characteristics shared by a person's cultural group. Identity allows for a self-definition. Factors that comprise an individual's cultural identity include race, ethnicity, country of origin, language use, religious beliefs, socioeconomic status, migration history, experience of acculturation, and the degree of affiliation with the individual's group of origin. Cultural identity emerges throughout the individual's

life and in social context. It is not a fixed trait of an individual or of the group of which the individual is part. An individual may have several cultural reference groups. The clinician should encourage the patient to describe the component aspects of their cultural identity. Evaluating the cultural identity of the patient allows identification of potential areas of strength and support that may enhance treatment effectiveness, as well as vulnerabilities that may interfere with the progress of treatment. Eliciting this data permits identification of unresolved cultural conflicts that may be addressed during treatment. These conflicts can be between the various aspects of the patient's identity and between traditional and mainstream cultural values and behavioral

expectations affecting the individual. Knowledge of the patient's cultural identity allows the clinician to avoid misconceptions based on inadequate background information or stereotypes related to race, ethnicity, and other aspects of cultural identity. In addition, it assists in building rapport because the clinician is attempting to understand the individual as a person and not just a representative of the cultural groups that have shaped the patient's identity. Cultural Explanations of the Individual's Illness The explanatory model of illness is the patient's understanding of and attempt to explain why he or she became ill. The explanatory model defines the culturally acceptable means of expression of the symptoms of the illness or idioms of distress, the particular way individuals within a specific cultural group report symptoms and their behavioral response to them that are heavily influenced by cultural values. The cultural explanations of illness may also help define the sick role or behavior the patient assumes. The explanatory model of illness includes the patient's beliefs about their prognosis and the treatment options they would consider. The patient's explanatory model may be only vaguely conceptualized or may be quite clearly defined, and it may include several conceptual perspectives that could be in conflict with one another. Formulation of a collaborative model that is acceptable to both the clinician and the patient is the sought-for end point, which would include an agreed upon set of symptoms to be treated and an outline of treatment procedures to be used. Difficulties may arise when there are conceptual differences in the explanatory model of illness between clinician, patient, family, and community. Conflicts between the patient's and the clinician's explanatory models may lead to diminished rapport or treatment noncompliance. Conflicts between the patient's and the family's explanatory models of illness may result in lack of support from the family and family discord. Conflicts between the patient's and the community's explanatory models could lead to social isolation and stigmatization of the patient. Examples of the more common explanatory models of illness include the moral model, the religious model, the magical or supernatural explanatory model, the medical model, and the psychosocial stress model. The moral model implies that the patient's illness is caused by a moral defect such as selfishness or moral weakness. The religious model suggests that the patient is being punished for a religious failing or transgression. The magical or

supernatural explanatory model may involve attributions of sorcery or witchcraft as being the cause of the symptoms. The medical model attributes the patient's illness primarily to a biological etiology. The psychosocial model infers that overwhelming psychosocial stressors cause or are primary contributors to the illness. Culture has both direct and indirect effects on help-seeking behavior. In many cultural groups an individual and his or her family may minimize symptoms due to stigma associated with seeking assistance for psychiatric disorders. Culture affects the patient's expectations of treatment, such as whether the clinician should assume an authoritarian, paternalistic, egalitarian, or nondirective demeanor in the treatment process. Cultural Factors Related to Psychosocial Environment and Level of Functioning An understanding of the patient's family dynamics and cultural values is integral to assessing the patient's psychosocial environment. The definition of what constitutes a family and the roles of individuals in the family differ across cultures. This includes an understanding of the patient's cultural group and its relationship to the mainstream culture or cultures. It includes the patient's life experience of racial and ethnic discrimination. For immigrants and refugees, it includes the individual's and family's perceptions of the openness of the host society toward people of their country and region of origin, their racial, ethnic, religious, and other attributes. The patient and family may identify strongly or weakly with communal sources of support familiar from their country or region of origin, or they may identify along the same gradient with communal sources of support in the host culture.

Cultural Elements of the Relationship Between the Individual and the Clinician The cultural identity of the clinician and of the mental health team has an impact on patient care. The culture of the mental health care professional influences diagnosis and treatment. Clinicians who have an understanding of their own cultural identity may be better prepared to anticipate the cultural dynamics that may arise in interactions with people of diverse cultural backgrounds. Unacknowledged differences between the clinician's and patient's cultural identity can result in assessment and treatment that is unintentionally biased and stressful for all. Clinicians need to examine their assumptions about other cultures in order to be optimally effective in serving the culturally diverse patient populations that are the norm in most contemporary medical facilities. Culture influences transference and counter-transference in the clinical relationship between people seeking psychiatric care and their treating clinicians. Transference relationships and dynamics are affected when the patient and clinician have different cultural background characteristics. A perceived social power differential between the patient and clinician could lead to overcompliance, to resistance in exploration of

family and social conflict situations, or to the clinician being conceptualized as a cultural role model or stereotype. Overall Cultural Assessment for Diagnosis and Care The treatment plan should include the use of culturally appropriate health care and social services. Interventions also may be focused on the family and social levels. In making a psychiatric diagnosis the clinician should take into account principles of cultural relativism and not fall prone to category fallacy. Many psychiatric disorders show cross-cultural variation. Objective evaluation of the multiple possible effects of culture on psychopathology can be a challenging task for the clinician. Diagnostic dilemmas may arise in dealing with patients of diverse cultural backgrounds. Some of these dilemmas may include problems in judging distortion from reality, problems in assessing unfamiliar behaviors, and problems in distinguishing pathological from normal cultural behavior. MIGRATION, ACCULTURATION, AND ACCULTURATIVE STRESS From the time of the first major surge of immigration to the United States in the 1870s, and for the next 100 years, the predominant national sentiment toward immigrants, as in most other host countries, was that they should acculturate to the normative behaviors and values of the majority or mainstream culture of the host population. Most immigrants had the same wish to assimilate, to become part of the melting pot. This process of acculturative change can be seen as unidirectional, as individuals who identified themselves as part of immigrant, indigenous, and other minority groups both rejected and progressively lost distinctive aspects of their cultural heritage in favor of becoming part of the mainstream majority culture of the host country. In countries that encouraged this outcome of acculturation, people were expected to progress from unacculturated, through the gradient of minimally, moderately, and fully acculturated. The intensity of acculturative stress experienced by immigrant and other minority groups, and the individuals comprising those groups, has been directly proportional to the openness of the host government and population. The central issue is to what extent are immigrants' and other minority groups' customs, values, and differences from the majority population of the host country accepted, encouraged, and welcomed as an enrichment of the host country, as opposed to being seen as alien and unwelcome. The acceptance position encourages the cultural integration of immigrants, whereas the rejection position encourages either cultural exclusion or cultural assimilation. In order to assess the outcome of acculturative stress, for groups and their component individuals, two determining factors need to be considered. The first is the extent to which the group and its members value and wish to preserve their cultural uniqueness, including the language, beliefs, values, and social behaviors that define the group. The

second factor is the mirror-image issue of the extent to which the group and its members value and wish to increase their contact and involvement with other groups, particularly the majority culture. This conceptual framework leads to four possible outcomes of

acculturative stress that are not conceptualized along the unidirectional gradient from unacculturated to completely acculturated. The four possible outcomes are rejection, integration, assimilation, and marginalization. Rejection is characterized by individuals' wishes, both conscious and intuitive, to maintain their cultural integrity, whether by actively resisting the incorporation of the values and social behavior patterns of another cultural group or groups with whom they have regular contact, or by disengaging themselves from contact with and the influence of those other cultural groups. Some religious cults are examples of rejection. Integration, as an outcome of acculturative stress, derives from the wish to both maintain a firm sense of one's cultural heritage and not abandon those values and behavioral characteristics that define the uniqueness of one's culture of origin. At the same time, such individuals are able to incorporate enough of the value system and norms of behavior of the other cultural group with which they interact closely, to feel and behave like members of that cultural group, principally the majority host culture. Accordingly, the defining feature of integration is psychological: It is the gradual process of formulation of a bicultural identity, a sense of self that intertwines the unique characteristics of two cultures. Assimilation is the psychological process of the conscious and unconscious giving up of the unique characteristics of one's culture of origin in favor of the more or less complete incorporation of the values and behavioral characteristics of another cultural group, usually, but not always, the majority culture. Examples include involuntary migration, when war and social upheaval necessitate such changes for purposes of survival. However, there are many other life circumstances, including racial, ethnic, and religious discrimination, that motivate people to overlook, suppress, or deny aspects of their cultural heritage in an attempt to have a seamless fit within another group. The price of such an effort, in terms of intrapsychic conflict, can be high. Marginalization is defined by the psychological characteristics of rejection or the progressive loss of valuation of one's cultural heritage, while at the same time rejecting, or being alienated from, the defining values and behavioral norms of another cultural group, usually that of the majority population. This is the psychological outcome of acculturative stress that is closest to the concept of identity diffusion. PSYCHIATRIC ASSESSMENT OF IMMIGRANTS AND REFUGEES Migration History Mental illness among immigrants and refugees may have been present before migration, may have developed during the immigration process, such as during months or years living in refugee camps, or presented for the first time in the country of immigration. The immigration process and premigration trauma may precipitate the manifestation of underlying symptoms or result in exacerbation of a pre-existing disorder. Obtaining a thorough migration history will assist in understanding background and precipitating stressors and help guide development of an appropriate treatment plan.

The premigration history includes inquiry about the patient's social support network, social and psychological functioning, and significant premigration life events. Information about the country and region of origin, the family history in the country of origin—including an understanding of family members who may have decided not to immigrate—educational and work experiences in the country of origin, and prior socioeconomic status should be obtained. In addition, premigration political issues, trauma, war, and natural disaster faced by the patient and family in the country or region of origin should be explored. For those who had to escape persecution, warfare, or natural

disaster, what were the means of escape and what type of trauma was suffered prior to and during migration? Traumatic life events are not limited just to refugees. Immigration may result in losses of social networks, including family and friends; material losses, such as business, career, and property; and loss of the cultural milieu, including their familiar community and religious life. Premigration planning includes reasons for immigrating, duration and extent of planning, premigration aspirations, and beliefs about the host country. The type of migration experience, whether as voluntary immigrants or as unprepared refugees, can have profoundly different effects on migrants' mental health. The Mental Status Examination As with any patient, conducting a mental status examination is a central component of the psychiatric examination. However, its interpretation in culturally distinct groups and among immigrant populations requires caution, as it may be culturally biased. The patient's response is molded by his or her culture of origin, educational level, and type of acculturative adaptation. The components of the standardized mental status examination are the following: cooperation, appearance and behavior, speech, affect, thought process, thought content, cognition, insight, and judgment. Cultural differences are wide and varied in dress and grooming. Facial expressions and body movements used in the expression of affect may be more reflective of normal cultural manifestations than pathology. If the clinician is unfamiliar with the individual's culture and the patient's fluency in the language of the host country is limited, the clinician must use caution in interpreting disturbances of speech and thought process, perception, and affect. The presence of hallucinations, for example, can be easily misinterpreted, such as hearing encouraging or clarifying comments from deceased family members, normative experiences in many cultures. The clinician should not assume that the patient understands what the clinician is trying to communicate, and miscommunication involving use of interpreters is a common problem. The cognitive examination may be particularly tricky. Education and literacy have an important and biasing role. The patient may need adequate time to fully express himself or herself through repeating questions and restating questions in the effort to reduce miscommunication. Asking about the meaning of proverbs unfamiliar to the patient may be an inappropriate means of determining abstract thinking. An accurate mental status examination can be accomplished when one allows additional time for clarification of concepts.

IMMIGRATION ACCULTURATION AND MENTAL HEALTH Many countries have had difficulty coping with the surging numbers of migrants. This has led to greater restrictions on migrant numbers, partly in response to public sentiment that the social and cultural integrity of the nation has become threatened, even undermined, by waves of migrants from other countries and cultures. During the last 10 years, fears of terrorist violence and civil disruption have led many countries to adopt increasingly restrictive and sometimes punitive policies toward legal and illegal migrants, refugees, and asylum seekers. This trend has been observed in the United States, in some countries of the European Union, and in Australia. RACIAL AND ETHNIC DIFFERENCES IN PSYCHIATRIC DISORDERS IN THE UNITED STATES A number of community-based epidemiological studies in the United States have examined the rates of disorders across specific ethnic groups. These studies have found a lower than expected prevalence of psychiatric disorders among disadvantaged racial and ethnic minority groups in the United States. African Americans were found to have lower rates of major depression in the Epidemiological Catchment Area study. The lifetime prevalence rates for major depression for whites was 5.1 percent; for Hispanics, 4.4 percent; and for African Americans, 3.1 percent. African Americans, however, had higher rates for all lifetime disorders combined. This finding of differential rates could be explained by adjusting for socioeconomic status. The National Comorbidity Study (NCS) found lower lifetime prevalence rates

of mental illness among African Americans than whites, and in particular mood, anxiety, and substance use disorders. The lifetime rates for mood disorders were 19.8 percent for whites, 17.9 percent for Hispanic Americans, and 13.7 percent for African Americans. The National Health and Nutrition Examination Survey-III also found lifetime rates of major depression to be significantly higher among whites, 9.6 percent, than African Americans, 6.8 percent, or Mexican Americans, 6.7 percent. Although African Americans had lower lifetime risk of mood disorders than whites, once diagnosed they were more likely to remain persistently ill. NCS rates for anxiety disorders were 29.1 percent among whites, 28.4 percent for Hispanic Americans, and 24.7 percent for African Americans. The rates for lifetime substance use disorders for the three groups, whites, Hispanic Americans, and African Americans, were 29.5, 22.9, and 13.1 percent, respectively. Hispanic Americans, and in particular Mexican Americans, were found to be at lower risk for substance use and anxiety disorders than whites. In an epidemiological study conducted in Florida, substantially lower rates were observed among African Americans for both depressive disorders and substance use disorders. The lower rate for substance use disorders was also found in the National Epidemiological Survey on Alcohol and Related Conditions, with whites having a prevalence rate of 1-year alcohol use disorders of 8.9 percent, Hispanic Americans, 8.9 percent, African Americans, 6.9 percent, Asian Americans, 4.5 percent, and Native Americans, 12.2 percent. This study also found lower lifetime rates for major depression among Hispanic Americans, 10.9 percent, compared to whites, 17.8 percent. In 2007, the National Survey of American Life compared rates of major depression between Caribbean blacks, African Americans, and whites. Although there were no significant differences in 1-year prevalence between the three groups, lifetime rates were highest among whites, 17.9 percent, followed by Caribbean blacks, 12.9 percent, and African Americans, 10.4 percent. The chronicity of major depressive disorder was higher for both African Americans and Caribbean blacks, approximately 56 percent, while much lower for whites, 38.6 percent. This study

was consistent with findings from the NCS that concluded that members of disadvantaged racial and ethnic groups in the United States do not have an increased risk for psychiatric disorders; however, once diagnosed, they do tend to have more persistent disorders. Although African Americans have a lower prevalence rate for mood, anxiety, and substance use disorders, this may not be the case for schizophrenia. The Child Health and Development Study found that African Americans were about threefold more likely than whites to be diagnosed with schizophrenia. The association may be partly explained by African American families having lower socioeconomic status, a significant risk factor for schizophrenia. A more detailed examination of differences across racial groups was included in the National Comorbidity Study Replication (NCS-R). Non-Hispanic African Americans and Hispanic Americans were at significantly lower risk than non-Hispanic whites for anxiety disorders and mood disorders. Non-Hispanic African Americans had lower rates of substance use disorders than non-Hispanic whites. More specifically, both minority groups were at lower risk for depression, generalized anxiety disorder, and social phobia. In addition, Hispanic Americans had lower risk for dysthymia, oppositionaldefiant disorder, and attention-deficit/hyperactivity disorder. Non-Hispanic African Americans had lower risk for panic disorder, substance use disorders, and early onset impulse-control disorders. The lower rates among Hispanic Americans and African Americans compared to non-Hispanic whites appear to be due to reduced lifetime risk of disorders, as opposed to persistence of chronic disorders. The researchers concluded that the pattern of racial-ethnic differences in risk for psychiatric disorders suggests the presence of protective factors that originate in childhood and have generalized effects, as the

lower lifetime risk for both Hispanic Americans and African Americans begins prior to age 10 for depression and anxiety disorders. The retention of ethnic identification and participation in communal, religious, and other activities have been suggested as protective factors that may decrease the lifetime risk for psychiatric disorders in close-knit ethnic minority communities. Cultural differences in response to psychiatric diagnostic survey items may be another possible explanation for these findings. However, disadvantaged ethnic groups usually overreport in studies measuring psychological distress, whereas these studies find lower rates. DISCRIMINATION, MENTAL HEALTH, AND SERVICE UTILIZATION Disparities in Mental Health Services Studies, including recent ones, have shown that racial and ethnic minorities in the United States receive more limited mental health services than whites. Analysis of medical expenditures in the United States has shown that the mental health care system provides comparatively less care to African Americans and Hispanic Americans than to whites, even after controlling for income, education, and availability of health insurance. African Americans have about a 10 percent probability of receiving any mental health expenditure, compared to 20 percent for whites. Hispanic Americans are

about 40 percent less likely than whites to receive any mental health expenditure. Total mental health expenditure for Hispanic Americans is about 60 percent less than for whites. In addition, studies conducted over the last 25 years have shown that regardless of disorder diagnosed, African American psychiatric patients are more likely than white patients to be treated as inpatients, hospitalized involuntarily, placed in seclusion or restraints without evidence of greater degree of violence, and treated with higher doses of antipsychotic medications. These differences are not due to the greater severity of the disorders between white and African American patients. One hypothesis for this discrepancy of treatment between African American and white patients is that whites are more likely to seek out mental health care voluntarily than African Americans, and African Americans are more likely to enter the mental health care system through more coercive and less voluntary referral systems. African Americans are also more likely than whites to use emergency room services, resulting in more crisis-oriented help seeking and service utilization. Once hospitalized in an institution with predominantly white staff, African American patients may receive differential care as a result of discrimination. That is, service personnel who are not familiar with the illness concepts and behavioral norms of nonwhite groups, tend to assess minorities as more severely ill and more dangerous than patients of their own racial or ethnic group; consequently, such patients tend more often than white patients to be hospitalized involuntarily, placed in seclusion or restrains, and treated with higher doses of antipsychotic medications. African American patients assessed in psychiatric emergency services are more likely to be diagnosed with schizophrenia and substance abuse than matched white patients. White patients are more often diagnosed with a mood disorder. The cultural distance between the clinician and the patient can affect the degree of psychopathology inferred and the diagnosis given. These differences in diagnosis by race have also been found when comparable research diagnostic instruments have been used for patient assessment. Semistructured diagnostic instruments based on explicit diagnostic criteria do not necessarily eliminate racial disparities in diagnostic outcomes. It appears that the process that clinicians use to link symptom observations to diagnostic constructs may differ, in particular for schizophrenia, between African American and white patients. The pattern of psychotic symptoms that predicts a clinician making a diagnosis of schizophrenia in African American and white patients is different. Among African Americans patients loose associations, inappropriate affect, auditory hallucinations, and vague speech increased the likelihood of a

diagnosis of schizophrenia. Positive predictors for white patients were vague speech and loose associations. In addition, auditory hallucinations are more frequently attributed to African American patients. African Americans are less likely to have had outpatient treatment and longer delays in seeking care, and they present more severely ill. The reason for hospitalization was also different between African Americans and whites. African American patients were more likely to be admitted for some form of behavioral disturbance, whereas white patients were more likely to be admitted for cognitive or affective disturbances. In

addition, African Americans were more likely to have police or emergency service involvement, despite no racial differences in violence, suicidality, or substance use when assessed. Furthermore, African American patients are more likely, even after controlling for health insurance status, to be referred to public rather than private in-patient psychiatric facilities, suggesting racial bias in psychiatric emergency room assessment and recommended treatment. African American patients diagnosed with major depression are less likely to receive antidepressant medications than whites, and less likely to be treated with electroconvulsive therapy. These findings cannot be explained by demographic or socioeconomic differences. One explanation may be that there are conscious or unconscious biases in psychiatrists' treatment decisions. Although both African Americans and Hispanic Americans were less likely to fill an antidepressant prescription when diagnosed with depression, once a prescription was filled, they were just as likely as whites to receive an adequate course of treatment. These findings indicate that initiating care for depression is the biggest hurdle in overcoming these disparities. African American patients have been found to be more likely to be treated with depot rather than oral neuroleptics compared to whites, after controlling for the type and severity of illness. When treated with antipsychotic drugs, African Americans are less likely to receive second-generation antipsychotics than whites, placing them at increased risk for tardive dyskinesia and dystonia. These differences in antipsychotic prescribing patterns may be due to physicians' concern over an increased risk of diabetes among African Americans compared with whites, or may be due to physicians perceiving their symptoms differently. Disparities in mental health care for African Americans and Hispanic Americans have also been noted in studies conducted with adolescents. A disparity in prescription drug use for mental illness also has been found among Hispanic Americans and Asian Indian Americans. From 1996 to 2000, Asian Indian Americans were found to use prescription drugs 23.6 percent less than whites, whereas the differences between whites and African Americans and between whites and Hispanic Americans were 8.3 and 6.1 percent, respectively. Disparities in mental health service use among Asian American immigrants may be linked to language-based discrimination, although racial bias cannot be excluded. A study of Chinese Americans found a higher level of use of informal services and help seeking from friends and relatives for emotional problems. Those Chinese Americans who reported experiencing languagebased discrimination had a more negative attitude toward formal mental health services. Data on racial and ethnic differences in mental health counseling and psychotherapy are similar to the psychopharmacological studies showing disparities for minorities. A study examining visits to primary care physicians based on the National Ambulatory Medical Care Survey from 1997 to 2000 found that primary care physicians provided similar or higher rates of general health counseling to African American than white patients. However, the rates of mental health counseling were significantly lower for African American patients. The lower rate of mental health counseling among African

Americans may be due to decreased reporting of depressive symptoms, inadequate communication between African American patients and their primary care physicians, and decreased willingness to discuss mental health issues. On the other hand, another study utilizing the Medical Expenditure Panel Survey from 2000 found that African Americans were more likely than Hispanic Americans or whites to receive an adequate course of psychotherapy for depression. These findings suggest that initiating treatment is the biggest hurdle, and that once they are engaged in treatment, African Americans have high compliance with psychotherapy. RESEARCH IN TRANSCULTURAL PSYCHIATRY There are three perspectives, among other possible approaches, that offer great promise for future research in cultural psychiatry. The first would be based on identification of specific fields in general psychiatry that could be the subject of focused research from a cultural perspective. Topics of epidemiology and neurobiology could be assessed in this way. The former would address issues primarily in the public health arena, including stigmatization, racism, and the process of acculturation. A number of cultural variables should be considered in conducting cultural psychiatry research, including language, religion, traditions, beliefs, ethics, and gender orientation. The second would aim at the exploration of key concepts and/or instruments in culturally relevant clinical research. There are four key concepts: idioms of distress, social desirability, ethnographic data, and explanatory models. Idioms of distress are the specific ways in which different cultures or societies report ailments; behavioral responses to threatening or pathogenic factors; and the uniqueness in the style of description, nomenclature, and assessment of stress. Social desirability stems from the similarities or differences among cultures vis-à-vis the actual experiencing of stressful events. Members of some cultures may be more or less willing to suffer physical or emotional problems, thus showing different levels of vulnerability or resignation, resilience or acceptance. Issues of stigma in different cultural contexts contribute to this level of desirability or rejection. Third, ethnographic data should be included, together with strictly clinical data and laboratory analyses or tests, as well as narratives of life that enrich the descriptive aspects of the condition and expand on the surrounding sociocultural and interpersonal and environmental aspects of the experience. The fourth concept is explanatory models. Each culture explains pathology of any kind in its own distinctive way. The explanation includes not only the presumptive original cause, but also the impact of the adduced factors and the interpersonal exchanges and interactions that lead to the culturally accepted clinical diagnosis. A third approach attempts to combine the first two by examining different areas of research on the basis of the clinical dimensions of cultural psychiatry. This deals with conceptual, operational, and topical issues in the field now and in the future, including their biocultural connections. Conceptual Issues in Cultural Psychiatry

One of the primary issues in research in cultural psychiatry is the conceptual differentiation between culture and environment. Although generally accepted as the conceptual opposite of genetic, environment represents a very broad, polymorphic concept. It is therefore important to establish that, while perhaps part of that environmental set, culture and cultural factors in health and disease are terms of a different, even unique, nature. To what extent does culture apply to the clinical realities of psychiatry? Culture plays a role in both normality and psychopathology. The role of culture in psychiatric diagnosis is an excellent example of this conceptual issue. Furthermore, culture has an impact on treatment approaches, based on both conventional medical and psychiatric knowledge, and on the explanatory models. Finally, cultural variables have a role in prognosis and outcome. A conceptual debate exists between those who advocate an evidence-based approach to research and practice, versus those who assign a value-based view to everything clinical, more so if influenced by cultural factors. The value-based approach invokes

issues such as poverty, unemployment, internal and external migration, and natural and manmade disasters. Evidence may be found to support both positions in scientific research. Operational Issues in Cultural Psychiatry The dichotomy of normality and abnormality in human behavior is a crucial operational issue. Culture plays a definitive role in shaping these approaches. This raises the notion of relativism, a strong conceptual pillar in cultural psychiatry. Normality is a relative idea; that is, it varies in different cultural contexts. Another operational issue is that of the choice of cultural variables. Each one has a specific weight and impact on the occurrence of symptoms, syndromes, or clinical entities in psychiatry. Some of them may be essential in the assessment of a clinical topic, namely, language, education, religion, and gender orientation. An additional operational factor is the description, assessment, and testing of the strengths and weaknesses of an individual patient. Aspects of an individual's behavior, attitudes, disposition, sociability, occupational skills, and other factors are culturally determined. Culture plays a significant role in the perception of severity of symptoms, the disruption of the individual's functionality, and quality of life. The assessment of severity is also the result of the meaning attributed to causal or pathogenic factors of psychopathology. Judgments about level of dysfunction and the quality of a patient's life involve elusive concepts such as happiness, well-being, and peace of mind. Research on cultural psychiatry issues needs to take into account representativeness of the study populations and generalizability of the findings. Methodological rigor needs to be applied to the collection of demographic data, delineation of and differentiation between ethnic groups or subgroups, and measurement of demographic variables, symptoms, diagnosis, and culturally specific constructs. Many tests and questionnaires used in clinical settings and research have been

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