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Pitfalls and advice in transcultural diagnostics

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Introduction

Culture

A shared set of beliefs, norms, or values that will influence the meaning given to life events and experiences

Essential Components of Culture

- Culture:
 - Is learned
 - Refers to a system of meanings
 - Acts as a shaping template
 - Is taught and reproduced
 - Exists in a constant state of change
 - Includes patterns of both subjective and objective components of human behavior

Common Cultural Themes

- Each patient is unique:
 - Each patient is a member of one or more cultural, racial, or ethnic groups
 - Treatment needs to be individualized for each person
 - Each cultural or ethnic group shares beliefs that characterize illness and determine acceptable treatment; however, there may be variations in these beliefs within each group
 - When formulating a treatment plan, consider individual characteristics such as:
 - Education
 - Nationality
 - Faith
 - Level of acculturation

Common Cultural Themes (cont)

- Trust and respect
 - Establish trust through time, patience, and small talk
 - Be aware of cultural differences such as:
 - Establishing eye contact — avoided out of respect in several cultures
 - Opposite-sex touching between health care provider and patient — may be forbidden in certain groups (eg, Orthodox Jews and some Islamic groups)
 - Need for explanations of what will be done
 - Preferences for “natural” medicines

Common Cultural Themes (cont)

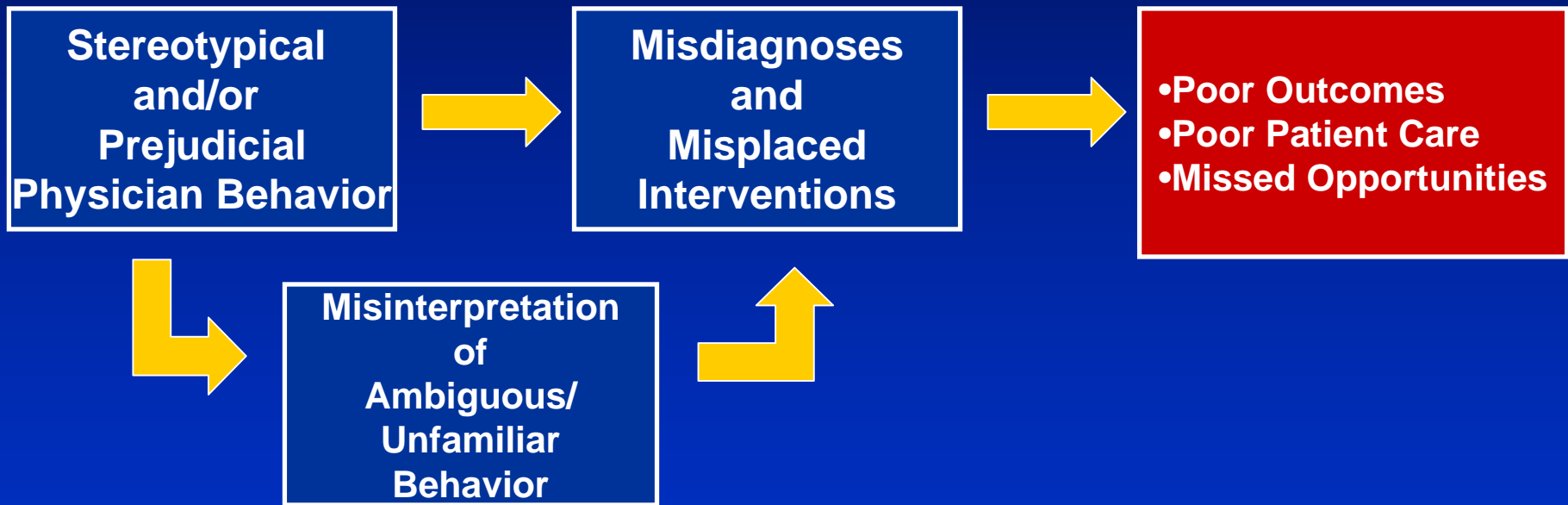
- Health beliefs and practices
 - Traditional healing is common
 - 95% of patients of Turkish origin consult with a healer; many of them rate the advice higher than that of their physician
 - many traditions may characterize diseases as “hot” or “cold” and manage them with alternative, herbal, or home remedies
 - Physicians should take advantage of opportunities to communicate with local medicine people [eg, hoca]
 - Fatalism or an attitude of passive acceptance may be encountered
 - Mistrust of Western medicine, physicians, and hospitals exists

Common Cultural Themes (cont)

- Family values
 - Family members' opinions about illness and treatment may be held in high esteem
 - An older family member may make health care decisions for the family
 - The family support system can greatly influence the patient's response to medication and therefore, clinical outcomes

Cultural Influences on the Patient–Provider Relationship

The Role of Myth and Stereotype



Does all mental distress need to be considered pathological?

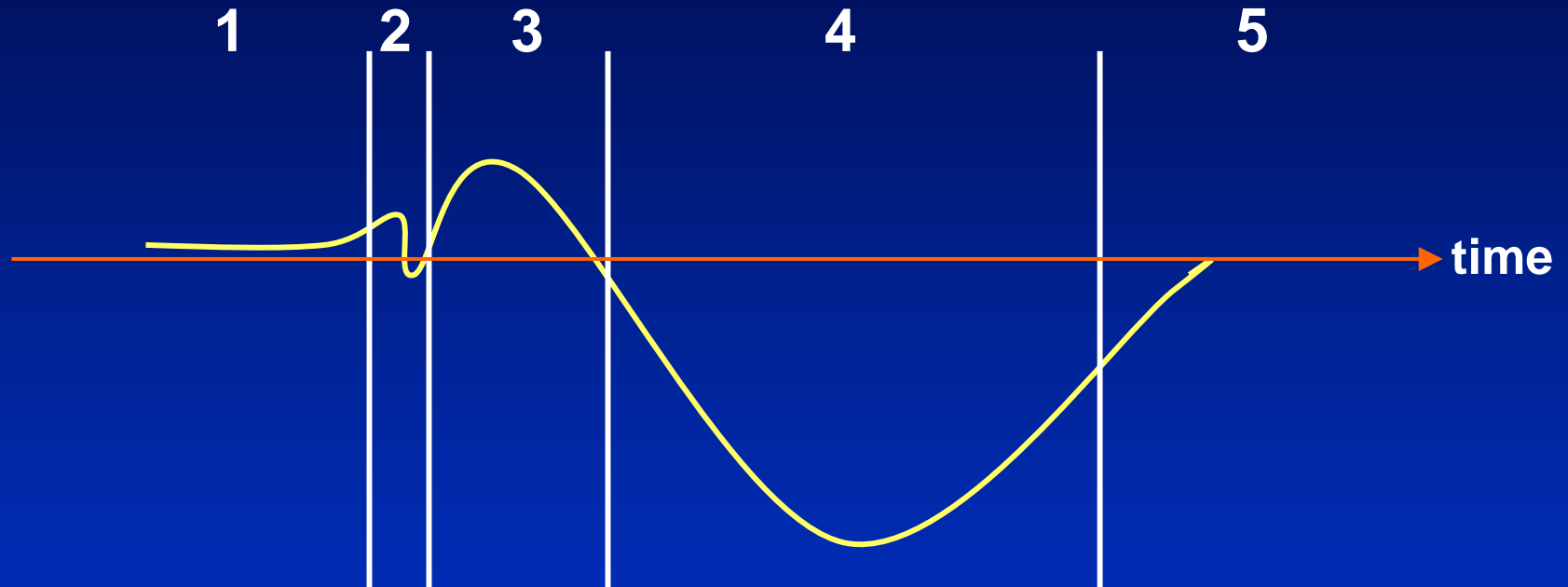
Comparison with

- Mourning after loss of a loved one
- Breaking up with girlfriend
- Stressful phase at work

Importance of comprehensive history taking

Stress model of migration

(Sluzki, 2001)



Phases:

- | | |
|---|------------------|
| 1 | preparation |
| 2 | migration |
| 3 | overcompensation |
| 4 | decompensation |
| 5 | acculturation |

Acculturation stressors

- Increased risks for psychological stress and mental illness:
 - History of political or religious persecution (including experiencing violence, imprisonment, or war)
 - Foreign language, custom, and acculturation stress
 - Social isolation and rejection/lack of social support
 - Racism and prejudice
 - Difficulty securing employment and housing
 - Limited health care access
 - Unattended chronic illness
 - Minority status

Acculturation

Patterns of Immigrant Adjustment			
<i>Pattern of Immigrant Adjustment</i>	<i>Demographic</i>	<i>Description</i>	<i>Resulting Psychological Stressor</i>
Old-line	Elderly	Rejection of new culture; Refusal to adapt	Can become isolated
Assimilative	Very young	Embraces new customs, relinquishes old	Can lose traditional supports, become vulnerable
Bicultural	Young adults	Selective adoption of new customs; maintains old	Can experience increased anxiety in meeting expectations

Diagnostic process

- Symptom - syndrome - diagnosis: cultural influence on all three levels
- Where is the border between normal & pathological?
 - Consensus between experts (universal diagnostic criteria?)
 - Deviation from the norm (cultural norms)
 - Evaluating the function (concept of illness)
 - Social evaluation (migrants are more often marginalized)

**Main factor affecting
diagnostic process among migrants:**

language

competency vs. understanding

Importance of second language

- **More cognitive, less emotional**
 - **DANGER: misdiagnosis**
- **Traumatic events can be more easily conveyed due to separation of affect from content (language independence)**
- **Most optimal: language switching**

Screening and Diagnosing — The Role of Culture

- Cultural explanatory models of illness
 - Define culturally acceptable symptoms of illness
 - “Idioms of distress”
 - Help define behavior the sick individual must assume

Screening and Diagnosing — The Role of Culture

- Types of models include:
 - **Religious/Spiritual:** Illness is punishment; atonement is necessary
 - **Magical:** Witchcraft, or sorcery causes illness; counteract with spell
 - **Moral:** Illness due to character flaw (eg, lazy, selfish); must improve
 - **Medical:** eg, Western allopathic medicine, Ayurvedic medicine, Chinese medicine

Somatization



- Presumed higher % of somatization among migrants: not confirmed by research
- Lowest agreement between self-ratings (e.g. SCL-90R) and expert ratings by clinicians

Screening and Diagnosing Somatization

- Somatization
 - Expressing psychological distress through bodily symptoms
 - Common in all cultural groups and societies
 - Culture specific with varying modicums of style
 - Depression can be displayed as low energy, insomnia, and physical pain, while mood symptoms are minimized
 - Can indicate
 - Physical or mental illness
 - Interpersonal conflict or positioning
 - Cultural idiom of distress
 - Metaphors for experience or emotion

Diagnostic issues for psychotic disorders among migrants



- If psychotic symptoms are present, not necessarily schizophrenia (potential for misdiagnosis 5x higher)
 - Short psychotic episode (ICD-10: F23)
 - Neurotic or mood disorders with psychotic symptoms
- Symptoms not necessarily psychotic
 - Belief vs. delusion
 - Hearing voices vs. hallucinations
 - Culturally adequate thoughts considered disordered
- Paranoia among refugees: delusional or real?
- Core syndrome of schizophrenia universal, behavior and affective expression differ

Misdiagnosis hypothesis

- Depressive disorder falsely diagnosed as schizophrenia (less often: schizophrenia diagnosed as depression)
 - Cultural factors affect presentation of disorder
 - Few mental health care professionals with migrant origin
 - Lack of cultural competence of mental health care professionals
- Possible explanation for increased rate of schizophrenia among migrants

Misdiagnosis of psychosis (Cochrane & Bal 1987)



- Hallucinations & delusions are taken to be indicative of schizophrenia, not true for patients from other cultural backgrounds
- Misinterpretation of thought processes as disordered or delusional - not pathological if viewed in their appropriate cultural context
- Psychogenic psychosis as reaction to stress more characteristic in other cultures (European equivalent: neurosis or depression)

Little empirical evidence for misdiagnosis hypothesis

- Review of records of bipolar patients: ethnicity significantly associated with misdiagnosis as schizophrenia (Mukherjee et al. 1983)
- More psychotic symptoms assessed when patients are interviewed in second language (Marcos et al. 1973)
- Germany: 32 Turkish patients with depression previously misdiagnosed as schizophrenia (Özek 1988)
- Preliminary study: records of migrants with schizophrenia diagnosis had higher rate of documented language problems (Haasen et al. 1997)

Misdiagnosis among Turkish migrants: controlled clinical study (Haasen et al. 2000)

- Methods:
 - Examination of 100 Turkish & 50 German patients with psychosis
 - Independent assessment by Turkish & German research psychiatrist using standardized diagnostic instrument (SCAN)
 - also compared to clinician's diagnosis



Misdiagnosis among Turkish migrants: controlled clinical study

- Results:
 - Diagnostic agreement among the 3 diagnoses:
 - 81% in Turkish sample, 96% in German sample (significant difference $p < 0.05$)
 - Within Turkish sample
 - no language problems: diagn. agreement 83%
 - Language problems: diagn. agreement 71%
 - **No statistical difference ($p > 0.05$)**
- Cases with disagreement: only half of them assessed as schizophrenia by Turkish psychiatrist

Misdiagnosis among Turkish migrants: controlled clinical study

- Results (2): Diagnostic agreement and psychopathology
 - Highest disagreement for delusions, especially paranoid delusions ($r = -0.48$)
 - Minimal disagreement / good agreement for hallucinations, e.g. acoustic hallucinations ($r = 0.38$)
 - Least disagreement / significant agreement for affective symptoms, e.g. depressive symptoms ($r = 0.51$)

Misdiagnosis among Turkish migrants: controlled clinical study

- Multiple regression analysis:
 - diagnostic agreement as dependent variable
 - Age, gender, age at migration, age at onset of illness, German language proficiency as independent variables

Only ***young age at migration*** was predictor for diagnostic agreement

Comparison of Turkish & German patients with schizophrenia (Haasen et al. 2001)

- Methods:
 - From clinical controlled study only those patients included with diagnostic agreement for paranoid schizophrenia (ICD-10: F20.0)
 - Turkish sample: N=63; German sample: N=41
 - Comparison of PANSS & HAM-D scores

Comparison of Turkish & German patients with schizophrenia

- Turkish sample scored higher in
 - PANSS total score ($p < 0.05$)
 - PANSS-items ($p < 0.05$): only significant differences in G3 (guilt feelings) and G14 (reduced impulse control)
 - PANSS hostile syndrome ($p < 0.05$)
 - HAM-D total score ($p < 0.05$)
 - HAM-D ($p < 0.05$): only significant difference in item 13 (general body symptoms)
- No difference in positive, cognitive, depressive or negative syndromes according to PANSS



Diagnostic issues for anxiety disorders among migrants

- Cultural differences in the relative weight of cognitive, emotional, somatic and behavioral aspects of anxiety: somatization disorder as frequent misdiagnosis
- Cognitive symptoms of anxiety disorders can even present as psychotic symptoms: misdiagnosis as schizophrenia
- High cultural dependence for phobias
- Underestimation of “adequate” fears due to discrimination

Culture & Anxiety Disorders

- Normal response? Symptom? Or Syndrome?
- Is there a problem with the way anxiety is being measured?
- Applying standardized anxiety instruments cross-culturally.
 - Low levels of anxiety found among Australian natives (Kidson & Jones, 1968) and Nigerians (Collis, 1966)
 - High levels of anxiety found among Arabs (Carstairs & Kapur, 1976) and Asians (Uba, 1994).
- Concept of anxiety and its manifestations may vary across cultures (Al-Issa & Oudiji, 1998)
 - Standard measures can under-estimate or over-estimate levels of anxiety in a particular culture.

Some culture-specific anxiety reactions

- Shinkeishitsu (Japan)
 - Ordinary neurasthenia
 - Panic symptoms
 - Taijinkyofusho (TKS; obsessive-phobic state)
- Brain-Fag syndrome (Nigeria)
- Koro (Chinese Shuk yang)
- Ataque de nervios (Latin Americans)
- Waswas (Muslims)
- Purity mania (Hindus)

Diagnostic issues for mood disorders among migrants



- Lack of depressive symptoms: misdiagnosis as somatization or dissociative disorder
- Melancholic mood not perceived as symptom: disorder not diagnosed
- Underestimation of stress associated with migration and acculturation: disorder not diagnosed

Postpartum Depression (PPD)

- research suggests that *immigrant mothers* from diverse cultures may be at higher risk to develop postpartum depression
- While several studies provide evidence that traditional postpartum rituals are followed by the majority of women in their native country, limited research has been conducted related to the practice of these rituals post-migration
- Australian study found that 18% of immigrant Chinese mothers felt *ambivalent* about traditional practices and that the reason they followed the practice was to *please* their in-laws (Matthey, Panasetis, & Barnett, 2002)

Dennis, C-L., Janssen, P., & Singer, J. (2004). Identifying Women At-Risk for Postpartum Depression in the Immediate Postpartum Period: Development of a Multifactorial Predictive Model. *Acta Psychiatrica Scandinavica*, 110, 338-346

Risk Factor	Beta	OR	95% CI
Immigrated within last five years	1.60	4.94	1.00-24.8
History of depression before pregnancy	0.60	1.82	1.05-3.16
Vulnerable personality	0.20	1.21	1.13-1.31
Life stressors	0.12	1.12	1.01-1.24
Pregnancy-induced hypertension	1.28	3.62	1.05-9.74
Global support	-.04	0.96	0.93-0.99
Satisfaction with infant feeding method	.83	2.29	1.13-4.64

PPD: consequences

- Understanding of the different ways in which mothers **conceptualize**, explain, and report symptoms of depression
- The **term** 'postpartum depression' may not be acceptable to many mothers and an alternative approach to recognition and management may be required
- Involve the use of symptom and **context-based terms** such as tension, weakness, and difficulties in one's relationship at home
- Be aware of traditional postpartum practices and understand the **rationale** behind such practices
- What is the **meaning** of traditional practices to the mother?
- **Devaluing** traditional practices based on a woman's cultural group could mean devaluing the mother as a person

Addiction



- Differences in patterns of use
- How integrated is use of substance in country of origin?
 - Alcohol: migrants from Muslim countries have lower risk, but if alcohol use is started, high risk of dependence
 - Opiates: irregular opium use without dependence is common in Iran

Culturally sensitive diagnostic evaluation

- Assess culture specific history: place of birth, structure of society at place of origin, family history, process of migration, difficulties of acculturation
- Different causal attributions: be aware of risk of overemphasizing as well as underemphasizing cultural factors
- Language factor: be aware of potential and risks of working in second language of patient

Final Thoughts

Cultural sensitivity

is

possessing some knowledge of differences,
possessing awareness and interest,
and possessing respect

for other cultures

Final Thoughts — Cultural Humility

“...incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.”

**A respectful attitude
toward multicultural perspectives**

“...does not require mastery of lists of “different” or peculiar beliefs and behaviors...[Rather, it is] a respectful partnership with each patient through patient-focused interviewing, exploring similarities and differences between [the physician’s] own and each patient’s priorities, goals, and capacities.”

Final Thoughts — Cultural Humility

- Create an attitude of learning about cultural differences in patient encounters
- Acknowledge the presence of differing belief systems and cultural values
- Remember that each patient is a unique member of one or more cultural, racial, or ethnic groups
- Provide individualized treatment to each patient
- Realize that, while each cultural or ethnic group shares beliefs that characterize illness and determine acceptable treatment, these beliefs may vary within each group
- Avoid stereotyping and overgeneralizations

Thanks for your attention!!!

Questions???