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Severe mental illness across cultures

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Objective: International studies have shown that the outcome of illnesses like schizophrenia vary across cultures. The good outcome in developing countries depends upon a number of factors.
Method: Using both primary and secondary sources, existing literature was reviewed. Using terms severe mental illness, culture and schizophrenia, Medline, Psychinfo and Embase were searched. Further searches were conducted using secondary searches.
Results: The impact of culture and its components on the individual and their families influences compliance, engagement with services and expectations of treatment. Cultures also impact upon identity and explanatory models of individuals.
Conclusion: Severe mental illness is as likely to be affected by culture as other illnesses. Clinicians need to use multi-model assessment and management techniques.

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Introduction

A proportion of patients with psychiatric illnesses are likely to become chronic. The chronicity of illness implies that there may be a risk of relapse over a long time or that the illness may continue with varying levels of psychopathology and, within this setup, acute exacerbations may occur in response to stressors. This exacerbation may well be related to partial or incomplete treatment. In addition, with chronic severe mental illness, denial and disability may occur.

The biological model indicates that the chronic disease is a result of biological vulnerability. Making the correct diagnosis as a result of thorough assessment is helpful in setting up the management. However, it must be emphasized that diagnosis itself must be seen in the context of culture at a broader level and individual and family needs at a personal level. This allows the clinicians to be aware of the interaction of culture in generating or protecting the individual pathology.

Literature review

The disability following a severe mental illness may be primary, i.e. resulting from continuation of symptoms or ongoing deficits in cognitive processes because of the illness, secondary, because of lack of motivation or demoralization because of persistence of symptoms and/or tertiary, because of social rejection or stigma as a result of exhibiting illness-related behaviours (1).

Culture is best defined as a common heritage or set of beliefs, norms and values (2), which are shared among a large group of people. Culture refers to these attributes as shared meanings, which can be acquired at different levels through different methods of learning, e.g. from child rearing, peers, schools, other institutions.

The role of culture in helping clinicians reached diagnoses and setup management plans is paramount (3).

This becomes even more urgent if patient and a clinician came from different cultural backgrounds. Culture needs to be differentiated from ethnicity, which refers to a common heritage (including similar history, language and beliefs; (4) but it is also self-ascribed. Culture can be fluid whereas ethnicity or ethnic identity is more likely to remain the same. In contrast, race overlaps with ethnicity but has a very social meaning (1) and also has a biological component. Culture structures the way people define what is abnormal and deviant, how illness is defined and how and where help is sought, as it is the culture that determines what resources are available for

managing what kind of distress. The understanding of culture allows us to identify the precise role culture may play in individual's lifespan of illness. For example, culture can precipitate illness, continue to define something as abnormal thereby perpetuating it, may act as the protector by providing structures which allow the individual to deal with the distress. Tseng (5) has highlighted functions of culture as pathogenic, pathoplastic, pathoselective, pathoelaborating pathofacilitative and pathoreactive. Each type of impact has different implications for the individual.

Aims of this study

The variation in rates of chronic severe mental illness across different ethnic groups and cultures is of great interest to both clinicians and researchers. The present paper describes some of the findings across different cultures.

Material and methods

Using key words culture, chronic mental illness, severe mental illness, schizophrenia and chronic depression, literature searches were carried out in major data bases such as Embase, Medline, Psychinfo and subsequent searches were secondary to trace all papers in English which fulfilled these criteria. The present paper provides a selective review, as not enough information could be gathered using these strategies.

Results

Several epidemiological studies, which have included several cultures, nations and societies demonstrated that rates of psychiatric disorders vary across cultures.

The concept of chronic severe mental illness is generally employed to denote chronic schizophrenia or bipolar disorders. However, there are major methodological problems in outcome research. These include varying periods of follow-up, varying methods of patient selection, varying considerations given to (or completely ignored) mediating cultural and social factors, economic conditions, employment, social support available and varying follow-up strategies.

Schizophrenia

Bearing in mind the problems in defining schizophrenia in early studies, the epidemiological and follow-up studies have to be seen in that context. The concept of schizophrenia is Western European and has raised several problems in diagnoses in other cultures.

Bipolar disorders

The symptoms of disinhibition will vary in hypomania according to cultures. The data on chronicity of bipolar disorders across cultures are not robust enough to draw any firm conclusions.

Discussion

There are some clear factors in identifying risk factors. For example, males develop schizophrenia at a slightly earlier age when compared with females. In the International Pilot study of Schizophrenia (6) and Determinants of Outcome of Severe Mental Disorders (7), it emerged that the rates of narrow definition schizophrenia were broadly similar across nations but broader definition schizophrenia varied nearly twofold. The incident rates in the second study (7) were identified by including patients who contacted any help giving agency for the first time ever in their lifetime. They were then interviewed by trained researchers using standardized instruments and pathways of care were determined. Both clinical and research diagnoses were used and incidence rates obtained. Narrow definition schizophrenia, which corresponds very closely with Schneiderian first rank symptoms showed no difference across different centres.

However, in spite of the variation in broad category schizophrenia, no consistent differences were reported between cases meeting the broad category only and those with narrow definition in either the course or outcome or onset of the illness. However, Cohen (8) has very cogently argued that the researcher's focus on narrow definition of schizophrenia and ignoring broad definitions does not deal with the relativist position of symptoms.

In 2-year follow-up data, Jablensky et al. (7) observed that in developed countries 39.8% had severe outcome compared with 24% in developing countries. Thus, sociocultural setting, i.e. developing or developed country, was the best predictor of 2- and 5-year outcome in both WHO studies (6, 7). These short-term differences may indicate more family support, less expressed emotion, low stigma to mental illness or some other mediating factors. However, it is also likely that prevalence of different symptoms may well vary. Acute transient psychoses are more likely in developing countries, which may also be related to organic infective factors, which will have better outcome. It is also

entirely possible that stressors may influence the course and outcome of the illness and the stressors may have specific cultural impact.

Thus, there is evidence to indicate that the outcome of schizophrenia is better in developing countries. The possibility that the observed differences in outcome can simply be explained by different composition of patient samples cannot be completely ruled out although it is possible that symptoms and their response to management may well differ.

Jablensky (9) proposes that as outcome of other psychoses such as paranoid psychoses was better in developing countries the impact of culture on outcome may well be non-specific and general. This impact may be a result of effects of beliefs and expectations about mental illness, strong social support networks and a non-stigmatizing sick role especially in the early stages of onset.

This better outcome has been shown in migrant groups in some studies but not consistently and not in all migrant groups, and the rates and outcome of schizophrenia in migrant communities in the UK have illustrated varying patterns (10). Marked differences in family setups, ethnic density and social structures, which can be demonstrated between the Asian and the African Caribbean communities suggest that the likelihood of better patterns of outcome in a new setting will rely on how the migrant groups have maintained their traditional cultural ways and values. This along with ethnic density and group cohesion may well explain some of the discrepancies in outcome (11). Another possibility is cultural congruity and cultural identity (12). The patterns of engagement, compliance and varying explanatory models may contribute to differences in outcome. External locus of control and biomedical models of explanation may be mediating factors in engagement.

Associated risk factors for poor outcome have been shown to be single, divorced, separated, males, high expressed emotion, poor psychosocial adjustment, social isolation, adjustment problems in adolescence, prolonged duration of the pre-index illness, insidious onset, negative symptoms, abnormal MRI scan and social withdrawal (9).

In the UK, it has been shown that Asians with psychosis are more likely to be married, living at home and treated at home and there were more older females in this sample (10) although African Caribbeans were more likely to have been living alone and being unemployed. In addition, African Caribbean males were shown to have been separated from their fathers for longer than 4 years in their childhood. This may indicate poor, insecure patterns of attachment which if replicated in adulthood will also indicate that attachment for therapeutic interactions is likely to be poor and insecure as well.

Thus several candidates for future research in trying to understand the factors in course and outcome of schizophrenia across cultures emerge. These include stigma, patterns of childhood attachment, ethnic density but going beyond simple numbers and trying to understand whether individuals who may be egocentric but come from sociocentric societies who migrate to egocentric societies may cope and adjust well when compared with sociocentric individuals from sociocentric societies who migrate to egocentric societies who may feel alienated if adequate social support structures are not available to them, thereby increasing their isolation and alienation, thus reducing the likelihood of engagement and change in outcome of the illness.

Bipolar disorders

There have been fewer studies of bipolar disorders across cultures. However, there has been at least one well-designed study looking at patterns of depression across cultures. Sartorius et al. (13) reported on symptoms of depression from Basel, Montreal, Nagasaki, Tokyo and Teheran. By using specific inclusion criteria and using an open-ended questionnaire to obtain culture specific items they found that the two commonest symptoms of depression were sadness and joylessness. Interestingly, suicidal ideas were less likely in the samples in Teheran and Tokyo. In Basel and Montreal feelings of guilt and self-reproach were observed. Unusually, no case of psychotic depression was reported from Teheran. The variations in symptoms within the same country have been reported as well (14).

The rates of depression and symptoms of depression do not vary dramatically among White population and Black and ethnic minority populations. Interestingly, among South Asians in the UK, length of time since migration, speaking English language, experience of racial prejudice and presence of children at home all influence rates of depression (15).

Assessment of the chronically severely mentally ill patients

The key aim of the assessment is to understand the experience of illness and not focus simply on disease. The disease is literally dise-ase, indicating an underlying pathology, whereas illness is broadening of this experience into psychosocial entity involving those around the individual. It is here in

this development of disease into illness experience that culture starts to play a significant role. It is the culture which determines what illness is, how sick role is defined and what help is sought. Thus in assessment, in addition to assessing the general risk factors of schizophrenia or chronic severe mental illness, it is essential that an element of assessment of world view of the patient and their carers and also the cultural aspects of definition of abnormal behaviour are understood. The clinician needs to assess the core of the illness by peeling away the layers of illness behaviour and discovering the treatable centre. These are, of course, multiple layers and highly variable across cultures. The understanding of these depends upon the therapist–patient interaction.

The assessment therefore must be at both individual and general cultural levels. It is necessary to emphasize that these are not mutually exclusive but a convenient way of dividing the processes involved in the assessment of the patient.

Individual factors

Individual factors have to be seen in the context of both the clinician and the patient. Therapists whose cultural background differ from that of their patients also need to be aware of differences according to age and gender and their professional status. It is quite likely that under these circumstances, there is an imbalance of power, which might work against the patient. Patients especially from migrant or minority communities will have to be assessed regarding their cultural and ethnic identity. It is worth emphasizing that identity is not static and will change according to acculturation. Use of verbal and non-verbal communication is also quite likely to shift accordingly. Additional factors such as experiences of alienation, racism and altered expectations of achievement play some role in the presentation and help seeking by the patient and their carers (see Table 1). Carers are a fruitful source of not only corroborating the history but also providing information on culture and cultural norms.

The world view of the patient may well differ from that of the therapist. The world view is defined as the means of understanding events and situations and is a direct result of cultural factors. For example, western views in many countries are individualistic rather than kinship-based and these act on self-actualization and a linear interpretation of events. Such generalization provides useful hints to the therapist in trying to understand their own assumptions and world view (16). The world view

Table 1. Assessment of risk factors

General
  Differential rates across cultures
  Differential outcomes across cultures
    Low EE
    Low stigma
    Family support
Individual
  Vulnerability
    Biological – PBC, neuro development, genetic
    Psychological – schizoid, schizotypal
    Social – unemployment, poor housing, ethnic density
  Stressors
    Life events
    Chronic difficulties

does not remain static and shifts with acculturation. Individual identity and world view often go hand-in-hand. With chronicity of mental illness the identity may well shift too. In an interesting study, Bhugra (17) showed that ethnic identity of patients with schizophrenia led them to see themselves as belonging to a different ethnicity under the influence of their psychopathology. For example, some Black patients either thought they were White or wanted to be White, where some White patients saw themselves as Chinese. In the context of severe mental illness, this phenomenon has been underestimated.

As mentioned earlier, cultures stigmatize or destigmatize mental illness. This may be one reason why some cultures use physical symptoms in preference to psychological symptoms. These developments also direct the patient to different help seeking agencies. For example, Wang et al. (18) demonstrated that 23% of their sample were more likely to approach the clergy even when they were suffering from seriously impairing mental disorders. Thus the clinicians must attempt to formulate pathways their patients have chosen in seeking help.

Certain behaviours and experiences may be seen as abnormal in some cultures but completely normal in others. The clinician therefore must employ verbal and non-verbal skills in observing and interviews. Crying, aggression, and loud speech are behaviours which are influenced by cultural mores, and the clinician must be sensitive in not reading too much into these. The use of external locus of control, i.e. patient stating that the fault is in their stars or in their fate must not be interpreted as ideas of reference or delusions of control. By definition, in order to understand the beliefs as delusional, a degree of knowledge of cultural background is indicated in order to embed these ideas in their proper context. In order to understand these ideas the clinician can draw from the

wealth of information available from those around the patient including family, friends, user groups, voluntary groups and support groups. These beliefs may be recorded and explored with these experts in the patient's culture to avoid misclassification (19).

Management

A clear conceptual framework, which includes biological, psychological and social factors must be put in place. Cultural factors will influence all these spheres to a varying degree. The clinician must also be aware of chronicity, potential for deterioration, denial and disability. Both short-term and long-term interventions in rehabilitation are necessary. The strategy for managing chronic severely mentally ill patients across cultures is no different except for a few additional factors.

Physical management

In managing patients with chronic severe mental illness several cultural factors need to be remembered. Pharmacokinetics of drugs vary across ethnic groups. Asians and Black patients showed higher blood levels of neuroleptics and also more side-effects at lower dosages. Asians also have a lesser need for high dosages of tricyclic antidepressants as blood and peak levels are reached earlier. Even within the same ethnic group lithium levels display highly variable serum levels (20).

Some ethnic groups are more likely to be treated with different medications – for example, African–Americans have been shown to be treated with conventional neuroleptics compared with White Americans who get atypical neuroleptics (21). Thus it is not entirely surprising that levels of compliance in certain ethnic groups are poor.

The clinician must explore explanatory models of patients' illnesses and decide whether the patients and the clinician's models can be brought to work together. Symptoms which may have significant personal meaning to the patient must be taken seriously. The patient's beliefs in traditional and complementary medicine may take them to use drugs, which may interact with prescribed medication. The commonest example of this in clinical practice is when patients use St John's Wort when they feel low, even when they have been prescribed antidepressants. Treatment compliance is also an important factor. In order to increase compliance the clinician must explain the treatment strategies in culturally meaningful ways, which would facilitate mutual trust. Educating patients must include cultural explanations and cultural expectations.

Table 2. Controlling and managing symptoms

Check the diagnosis
Ensure adequate losses of drugs over a specific period at least
  to see if these work
Therapeutic levels may be indicated
If poor response, check compliance
If compliance good consider changing drugs
Try and change only one drug at a time
Try and change typicals to atypicals if indicated
Do not try and treat every single symptom
Check diet, dietary taboos, alternative medication
Check on smoking, alcohol etc.

Other non-biological factors, which will affect medication compliance include personality styles such as culturally related differences in 'normative' personality traits. This has been indicated as the ability of some ethnic groups to become more sedated on equivalent dosage of medication because the personality style is less-action oriented.

Social support systems will influence compliance especially if the patient comes from a sociocentric culture where kinship may take part in decision-making. Thus, the explanatory models may well conflict with those of the patient or the clinician and lead to conflict and poor compliance.

Communication and language will also influence engagement and compliance. Table 2 illustrates some of the principles which apply equally across cultures. It is important to remember that drug management does not work in isolation and will have to form a part of wider biopsychosocial management.

Psychosocial management

Different types of psychosocial therapies can be culture specific or certainly culture bound. Psycho-analytical therapy is very much embedded in western egocentric tradition and is less likely to be successful across cultures and has limited application in managing chronic severe mental illness. Of greater benefit are cognitive and behaviour therapies. Assessing cognitive deficits and setting in place cognitive therapies across cultures is not an easy task. Firstly, norms of cognitions are not universal. The triad of I am a failure, the future is bleak and the world is a horrible place derives from America, and its application to patients from other cultures whose concepts of I-ness (or self) are different must be very carefully applied.

Behavioural therapy is generally more adaptable across cultures, which is because of its practical nature. It requires little interpreter time, the therapy is specific as is outcome. However, in some societies with the notion of arranging

marriages is paramount, training in social skills to go out on dates is bound to create resentment. Thus, a careful analysis of cultural norms prior to considering behavioural therapy will provide great dividends.

The use of intercultural therapies which bridge European models with traditional indigenous therapies can be useful. This means developing psychotherapies which are culture-specific and combining them with culturally sensitive psychotherapies available elsewhere. Such adaptations are not necessarily easy but can be very fruitful. For example, using yoga as meditation to reduce anxiety rather than relaxation therapy will be more acceptable to some patients, they will also welcome the inherent cultural–religious belief systems. However, a note of caution is necessary. Just because the patient originates from India does not mean they will automatically take to yoga. The clinicians therefore must avoid stereotyping.

Some groups will use pluralistic approaches to healthcare. They may combine Western systems with Ayurvedic, homoeopathic or Unani systems and the clinician must ensure that the scope of interaction between different models is minimal. That patients from some cultures will also use religious and non-medical healers shows the need for clinicians to be aware of these. Some of these therapists will provide a degree of psychosocial as well as social management.

Social management

Using social approaches to identify the social causation and putting management in place may require the teams to have members who can provide such an expertise. Using non-governmental organizations may well provide a more acceptable inroad into engaging patients. However, the question of confidentiality and stigma must be remembered. Using interpreters who are not trained may complicate matters further. Using social services may indicate a failure of the kinship system in the eyes of some ethnic minority groups. They may see social workers as a key to better accommodation or employment without necessarily looking at the possibility of change.

Bhugra (19) recommends that the client's explanation of their symptoms should be seen as the starting point, which takes the focus away from psychiatric diagnosis. Such an approach allows the clinician to patch together a treatment package including in-patient, rehabilitation, crisis resolution or home treatment. Engaging user groups and voluntary organizations may allow them to act as advocates for patients. The user movement has a variable influence on psychiatric practice worldwide. It is especially strong in some countries and cultures, but not in all. The voluntary organizations often provide an excellent link between the community and the services but the danger is often lack of sustained funding, which may impact on their contributions. These agencies meet needs that may not be met by statutory agencies. Their autonomy is their strength, and working together with them without affecting their autonomy needs to be considered very seriously. The grass roots perspective provided by these agencies can prove to be extremely helpful in planning out strategies for both assessment and management.

Conclusions

There is no doubt that culture clothes the disease and turns it into illness. This changes across cultures as does the experience of disease. These cultural differences impinge upon symptoms, planning clinical assessment and planning multidisciplinary management. Both the clinician and the patient need to be aware of each other's explanatory models and worldview. Changes in cultural identity and perceived stigma of mental illness will influence how symptoms are identified and prevented for treatment. An acceptable service for patients from any culture is acceptable to them only if their needs are understood and clearly identified. This suggests that listening to the patients, their carers and also community at large will enable the clinician to provide help, which will substantially change the clinical outcome.

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