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Mental health in primary care: ways of working – the impact of culture

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ABSTRACT

This article reviews the literature to bring together aspects of culture and its impact on ways of working in mental health in primary care. It describes a case from primary care that demonstrates the complexity of developing cross-cultural formulations. It argues that if comprehensive and effective management of cross-cultural patients is to take place in general practice, primary care clinicians should take into account the cultural experience of the patient they are managing,

including their social situation. Such patients often present with multiple somatic complaints. In order to provide holistic care it recommends the use of a tetra-axial diagnostic classification and culturally sensitive questioning through professional interpreters as necessary.

Keywords: cross-cultural; consultation; tetra-axial formulation

Introduction

A general practitioner (GP) from New Zealand recently visited a general practice in east London and, noting the ethnic diversity of the patients attending the surgery, commented that what she had encountered was no different from her own experience in New Zealand. This observation was not altogether surprising, as the UK, along with other European countries as well as Australia, New Zealand, Canada and the USA, has witnessed an increase in ethnic diversity within its populations in recent years. Increasing globalisation, wars and famine have contributed to increasing immigration and the multiculturalisation of many industrialised countries. This brings a number of challenges to the GP, especially when dealing with mental health issues.

Increasingly family physicians recognise the biopsychosocial model of mental health care.^{1,2} General practice experience shows the importance

of culture in the presentation of illness and on diagnosis, and this is supported by evidence.^{3–9} Despite the recognition of the impact of culture upon illness, research in this field has been difficult because the standardised instruments available have been developed in western populations and are often of limited use in cross-cultural settings.^{10–12} Nevertheless a proposal for a cultural adaptation of nosological systems such as the American Diagnostic and Statistical Manual of Mental Disorders (DSM) and World Health Organization International Classification of Diseases (ICD) classifications was considered a retrograde step.^{13–15}

The purpose of this paper is to outline the impact of culture on aspects of mental illness in primary care by reviewing the literature and using a case study to demonstrate the complexity of practising medicine within a diverse community. The paper

hopes to provide an insight into the time, thinking and the practical as well as emotional resources necessary for cross-cultural working, and to propose a framework within which to conceptualise and better manage this challenge within general practice using the World Psychiatric Association tetra-axial formulation for diagnosis of mental illness in cross-cultural settings.¹⁶

What is culture?

Culture is a word that is freely used but is often difficult to define. Kroeber and Kluckhohn found over 164 definitions of the word culture in their review.¹⁷ Helman defined culture as 'a set of guidelines both explicit and implicit by which individuals interact as members of a particular society and also view the world. It also tells them how to experience and express emotion including how to relate to other people and supernatural beings'.⁶ Despite the plethora of definitions, a common theme is captured in the World Health Organization definition of culture as 'a cognitive map to make sense of the world and guide behaviour'.¹⁸

Culture and mental illness

In 1988 Leff posed a number of questions he believed needed to be answered in order to explore the relationship between culture and psychiatric illness.¹⁹ These included the following:

- are psychiatric conditions manifested similarly in different cultures?
- do psychiatric conditions have the same frequency in different cultures?
- are they treated differently in different cultures?

Cox applied some of these questions to perinatal mental disorder, and we will do likewise when considering the question of cultural impact on presentation and ways of working in primary care.⁵

Are psychiatric conditions manifested similarly in different cultures?

When the World Organization of Family Doctors (WONCA) recently developed a Culturally Sensitive Depression Guideline, the literature review supported the view that there is variation in the expression of

psychological distress across a variety of cultures.²⁰ Earlier western psychiatrists such as Carothers believed that dysphoric mood was purely a western phenomenon.²¹ Subsequent evidence in the literature is contrary to Carothers' view, and suggests that dysphoric mood is a universal phenomenon, which shows cultural variation in its expression.^{22,23} Kleinman *et al* noted that the definition and expression of disease, illness and distress vary across cultures.²⁴ Culture also influences the way individuals seek help.²⁵

A schema for conceptualising the cross-cultural interaction is described in Figure 1.

Do psychiatric conditions have the same frequency in different cultures?

Many psychiatric conditions managed in general practice tend to show a cultural variation in prevalence, except for nuclear schizophrenia, which has been found to have a similar prevalence worldwide.²⁶

Epidemiological studies have shown a transcultural variation in both the prevalence and presentation of depression. A prevalence of 2.6% in Japan compared to 29.5% in Chile was reported by Goldberg and Lecrubier, and 1.5% in Taiwan compared to 19% in Lebanon by Weissman *et al*.^{22,23} These differences may be spurious, related to variation in the diagnostic instruments used in different studies and their applicability to different cultures, or may represent true prevalence variations related to other factors such as biological and or psychosocial differences.

This issue becomes even more complicated in transcultural settings. An important reason for under-recognition of depression in immigrant populations in primary care may be that patients often use physical metaphors for psychic pain, especially in languages that do not include specific words for low mood. Patients from the Indian culture may use the words 'sinking heart', 'feeling hot' and 'gas' to communicate psychic distress.²⁷ Those from Nigeria describe 'heat in the head', 'biting sensation all over the body' and 'heaviness sensation all over the body'.²⁸ Turkish patients often complain of atypical facial pain, waking up tired in the morning, breathing difficulties, 'my head is empty' and 'I've got shattered nerves'.^{29,30}

Conditions that have a largely sociological aetiology such as post-traumatic stress disorder (PTSD), tend to show variation in prevalence depending on ethnicity, tragedies or wars. Suli and Çomo reported a 59% prevalence of PTSD in Kosovo refugees settled

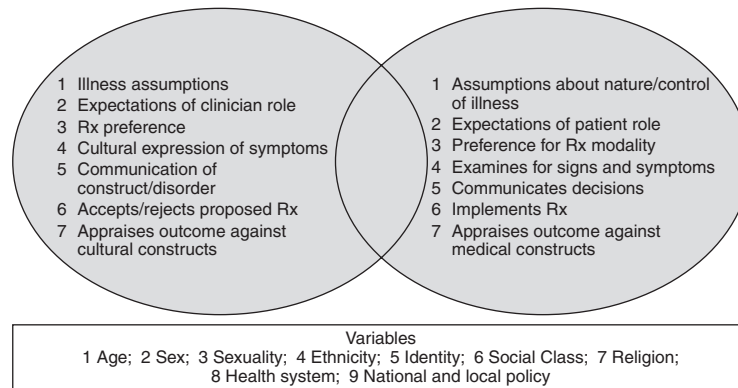


Figure 1 The patient–clinician cultural interface⁹

in Albania, which compared to 34% prevalence in Croatians tortured by Serbians and 65% of Bosnians who had settled in the USA.^{31–33}

PTSD is not a common finding in general practice, perhaps because primary care clinicians do not search for it. Alternatively patients suffering from PTSD may be preoccupied with other issues to which they believe the symptoms of PTSD are secondary. Many immigrants who have arrived in recent years and been seen by primary care in Europe may be refugees fleeing from conflict in their countries of origin (for example those from the Balkans, Somalia and others). It is therefore important for primary care clinicians to be mindful of the reasons a recent immigrant may have for leaving their country of origin when eliciting information as an essential part of history taking and mental state assessment.

Are psychiatric conditions treated differently in different cultures?

There have been many guidelines written to support primary care in the treatment of psychiatric disorders. The National Institute for Clinical Excellence (NICE) in the UK has produced guidelines for the management of schizophrenia, depression, anxiety disorders and PTSD based on evidence.³⁴ NICE has proposed a stepped care model for depression, with steps 1 to 3 applicable to primary care, and steps 4 and 5 applicable to specialist services and inpatient units.

Evidence from the psychiatric literature supports the view that there is cultural variation in response to available treatments. WONCA launched a culturally specific depression guideline in order to allow doctors to recognise and address these differences.²⁰ Patients of different ethnic background may show

differential response to both psychological and pharmacological treatments. For example patients of Asian origin have been reported to respond well to highly structured therapeutic interventions such as cognitive behaviour therapy, and to suffer from the side-effects of antidepressant or antipsychotic medication at lower doses than their white counterparts.³⁵ Other forms of therapy that have been found useful in culturally diverse populations include exercise and diet.³⁶

How does this translate into everyday GP practice?

The following case study requires us to understand what we mean by culture and its relationship to mental illness. It demonstrates that the presentation of an illness can be shaped by the sufferer's cultural experience, and that this can pose a diagnostic challenge for the practitioner whose own cultural background also has an impact on the clinical encounter. It also provides an illustration of the wide variety of resources that may need to be drawn upon when dealing with a cross-cultural consultation, so adding to the complexity of the therapeutic transaction.

Case study

Mr X, a 44-year-old Muslim Kosovo Albanian arrived in England as an asylum seeker with his wife and three children in 1998. Born in Eastern Kosovo, he completed a technical secondary school education and ran a small car business in his home town. While protesting against the closure of the local schools by Serbians in 1997, he was assaulted by police with a rifle and subsequently hospitalised for ten days. Six

months later he was arrested and tortured because of his involvement with the Democratic League of Kosovo. When his village was razed to the ground in 1998 he fled to Pristina, from where he and his family travelled to England via Dover by lorry. Immediately upon arrival in the UK he went to the Home Office Department in Croydon to register as an asylum seeker. His first asylum application was refused. He described an immediate feeling of insecurity, and developed flashbacks to his wartime experiences in Kosovo. He dates his problems as starting from then.

On reviewing his notes, Mr X has been registered with at least three GP practices in London and has presented with multiple somatic complaints. His consultation pattern with the NHS reveals that he contacted the health service three times in 1998 and not at all between 1999 and June 2001. He has made a total of over 133 contacts with the NHS since July 2001, when his first asylum application was rejected. He has been referred to the gastroenterologist for a number of investigations including endoscopy, which confirmed mild gastritis. A borderline haemoglobin level was confirmed after referral to a haematologist. He has had a battery of radiological investigations including a scan of his kidneys, ureter and bladder (KUB), all of which were normal. He has been referred to the general surgeons and, after being diagnosed with a lipoma, did not attend for his operation. He has presented to a number of different emergency departments with complaints diagnosed as atypical chest pain. He has been referred to a neurologist for investigation of recurrent headaches – nothing pathological was found. All ECGs and cardiac enzyme estimations have so far been normal, as has a cardiac stress test. He has been referred to a psychiatrist and missed the majority of his appointments.

He has attended a specialist traumatic stress clinic since 2004 for treatment of PTSD, anxiety disorder and panic disorder. These conditions are treated using family therapy. He has never received any individual psychological treatments. His GP has been treating him with antidepressant medication, as, despite his atypical presentation, the GP believes he is suffering from a depressive disorder. His situation is compounded by housing and benefits difficulties, the latter because he is late in completing the relevant documentation, if he completes it at all.

In one of his recent encounters at the GP surgery, he attended with an official NHS interpreter, his wife and his eldest child. While the senior GP was discussing the need to develop a therapeutic alliance, he suddenly held his chest. He appeared sweaty and was hyperventilating. He was laid on the examination couch, given 300 mg of aspirin, GTN spray and an ambulance was called. When the ambulance

arrived 10 minutes later, a 12-lead ECG was normal. He was nevertheless taken to the local emergency department and was found to have normal cardiac enzymes. Because of the dramatic nature of his presentation he was admitted overnight for observation. A cardiac stress test completed the following day was normal and he was discharged with a diagnosis of atypical chest pain.

He re-presented to the GP surgery on the afternoon of discharge, again clutching his chest. He declined the receptionist's offer of calling an ambulance, as there was no GP available until evening surgery. Instead, through an accompanying member of his family, he left a note written in English for his GP. He informed the GP that he needed a sick note to make another benefit claim, and it emerged that he was making an appeal about the fact that he had been refused disability living allowance.

When seen by the GP later that day he was told that there was no need to be so dramatic when expressing his distress, as the practice fully understood his needs. He is currently jointly managed with regular appointments from both the traumatic stress clinic and his GP. He is prescribed an antidepressant and a proton pump inhibitor.

Discussion

In the case vignette described above, Mr X and his family expressed their emotional distress by showing exaggerated physical symptoms. The true nature of these symptoms was initially unrecognised by the practice clinicians. It can be speculated that, had the nature of Mr X's problem been recognised earlier, his presentation may not have been so dramatic. If the case notes had been fully summarised, a simple administrative task, the clinician may have noticed a pattern in his presentation that would have led to the earlier recognition that his symptoms, although somatic, were of psychological origin. This illustrates the importance of better understanding the relationship between cultural background and mental illness, in order to minimise the need to refer the patient to multiple healthcare providers. How, then, might clinicians start to overcome some of the cultural barriers that they face in their day-to-day work?

Mr X's perception of the way he should seek help from a GP for the problem he had was different from the way the doctor conceptualised that Mr X's problem should present. Even though he was given GTN spray, aspirin, blood tests for cardiac enzymes, an ECG and an ambulance trip to the emergency department of the local district general

hospital where he underwent further investigation, his real need was a sick note, which at that time he was not given. This unmet need caused him to visit the GP the following day with an identical presentation, whereupon the receptionist told him that his behaviour was not going to get him anywhere. She urged him to inform her verbally of his 'real problem', which he did in writing through a family member. This demonstrates the special importance, when dealing with a culturally diverse population, of early good-quality collaboration with the patient.

Mr X suffers from PTSD for which he is receiving treatment from a trauma clinic and the practice simultaneously. GPs do not routinely provide feedback to specialist providers; however cases such as that of Mr X illustrate that good two-way communication between primary and secondary care allows each party to develop a clearer, more holistic biopsychosocial formulation of the problems presented. It is important for the general practice to communicate with the other agencies involved in providing care, as each party may have access to different elements of the patient's story. The simple measure of identifying a member of general practice staff who can adopt a role similar to that of a key worker may help to breach the cultural divide between the patient and all the organisations involved in providing care.

Conclusions

This paper has outlined some of the difficulties in cross-cultural working in general practice by using a case presentation and literature review. We have touched on the tension between those who advocate that a pure nosological classification of mental illness is the way forward, and those who maintain that culture plays a major role in the presentation of mental illness.

We are of the opinion that primary care clinicians need to be aware of how culture colours the presentation of psychiatric disorders, and to develop the skills to sift through this and establish the presence or absence of illness. Failing to do so may result in unnecessary high costs, both emotional and financial, to the individual, their family, the GP practice and the wider NHS. With all the changes within the NHS in the UK and the proposed move toward practice-based commissioning, lack of understanding of the aetiological factors underlying multiple somatic complaints may lead to unnecessary expenditure for both the local health economy and the practice.³⁷

Practical suggestions

When dealing with such complex cross-cultural presentations, part of the investigation should be an early full summary of the general practice case notes. If a pattern similar to that of Mr X is emerging, we recommend that the general practice should identify a case manager who may either be a member of the general practice staff, a graduate mental health worker or a medical care practitioner, whose role is to liaise with all the NHS providers involved so that the patient can be appropriately guided in their efforts to seek help.

It is important for GPs and their staff to be trained in the management of cross-cultural cases. Jadhav notes that in psychiatry, scholarly discourses on cultural psychiatry and medical anthropology remain confined to the academic institutions of high-income countries and have little impact on changes in everyday clinical practice.³⁸ Little wonder that many GPs may have little practical training in this very important aspect of their work. GPs are increasingly being provided with evidence-based guidelines for the management of a variety of clinical conditions from numerous sources. We recommend that when using guidelines in primary care, clinicians should consider cultural aspects of presentation, including response to treatment. Primary care mental health workers could very easily provide such a structured approach.³⁴ Practice nurses and the newly created medical care practitioners could be trained in cognitive behavioural therapy.

Mr X has demonstrated the need for primary care physicians to be culturally aware and sensitive. GPs would benefit from the use of appropriate interview schemas and questions to assist them in the cross-cultural therapeutic encounter. A tetra-axial schema would enable a more comprehensive conceptualisation of the medical problems presented in cross-cultural work. The tetra-axial formulation for the diagnosis of cases, proposed by the World Psychiatric Association as part of its International Guidelines for Diagnostic Assessment (IGDA; Box 1) could be usefully adopted.¹⁶

The above formulation can be very useful when dealing with cross-cultural cases, as it allows equal weighting to be given to the physical and psychological difficulties faced by the patient. It may facilitate joint working between the clinician and patient. Axes II and III record a number of factors that can be cultural in origin and include abuse, violence, housing, economic issues, legal status and educational issues. The individual's willingness to accept the treatment offered is also recorded under Axis III. Axis IV allows the patient to assess his or her own quality of life using a Likert scale. The IGDA schema is also useful for summarising complex cases and,

Box 1 WPA IGDA standardised tetra-axial diagnostic formulation¹⁶

- **Axis I:** clinical disorders (mental and general medical conditions)
- **Axis II:** disabilities (in personal care, occupational functioning with family, functioning with family and broader social functioning)
- **Axis III:** contextual factors (interpersonal and other psychosocial and environmental problems)
- **Axis IV:** quality of life (primarily reflecting patient's self-perception)

from this, a simple treatment plan using a holistic approach can be generated taking into account the patient's presentation.

A Cultural Awareness Tool (CAT) developed in Australia derived from the work of Kleinman *et al* could be very usefully applied in the patient assessment.^{12,39} The questions asked to capture the cultural context in which the patient lives are described in Box 2.

The questions described can be asked by any member of the primary care team, and provide knowledge of the patient's explanatory model of illness so that this can be used by the clinician to negotiate a treatment plan that the patient is likely to accept. In all assessments where the patient lacks

Box 2 Cultural awareness tool

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your problem does to you? What are the main problems it has caused for you?
- How severe is your problem? What do you fear most about it?
- What kind of treatment/help do you think you should receive?
- Within your own culture how would you be treated?
- Is your community helping you with your problem? How?
- What have you been doing so far for your problem?
- What are the most important results you hope to get from treatment?

From The Royal College of General Practitioners WA Research Unit³⁹

proficiency in the language of the therapeutic encounter, it is essential to seek the help of professional interpreters.

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CONFLICTS OF INTEREST

None.

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