# TRANSCULTURAL SENSITIVITY

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Psychiatry has gone through various phases and changes since its beginnings. In the United States, some of these changes, which are still going on, are: a transition from a medical model to a social model, the movement from institutional treatment to treatment in community mental health centers, and the introduction of different types of medication and modalities of treatment. The author has observed that there is even some change in the diagnostic thinking, which may or may not be attributed to new scientific information. For example, the once overused and often misapplied diagnosis of schizophrenia appears to be now replaced by the more acceptable diagnosis of manic-depressive syndrome. Thus, in the last several years, the use of lithium for treatment of this syndrome has become widespread. Various treatment modalities have also emerged and become popular in psychiatry. Some of these are: crisis intervention, brief therapy, family therapy, and transactional analysis. More recently, biofeedback, jogging, and meditation have entered the psychiatric network. However, when a clinician makes a psychiatric diagnosis, or considers a particular treatment modality, there is one important area that is often overlooked. That area is the appreciation of the many cultural components brought into the treatment setting both by the patient and the clinician. The author would like to define this as "transcultural sensitivity".

Transcultural psychiatry has been defined by Wittkower and Rin in the following way: The term transcultural psychiatry, which is an extension of cultural psychiatry, denotes that the vista of the scientific observer extends beyond the scope of one culture unit onto another.[1]

Thus, "transcultural sensitivity" can perhaps be further understood when divided into the two previously mentioned areas: first, the clinician's ability to be aware of the emotional, cultural, and physical variations of different ethnic groups, and second, the clinician's sensitivity to those aspects of his own background and personal preferences that may influence not only the choice of the treatment method, but also the outcome of the treatment itself. The author would like to elaborate further on these areas.

### Cultural Variations in Preferences for Treatment and Healing

There is an abundance of literature, largely from the field of anthropology, which explores many facets of ethnic-group diversity. But of concern in this paper are the preferences in different cultures, and their folk and scientific methods, for approaching healing and prevention.

In the Papago American Indian community in southern Arizona, laughing and joking are used as a mechanism against pain or danger.[2] Further, this same culture values the eating of beans as a source of strength and healing.[3] The coping mechanism of laughing and joking, when compared to the norms of the majority of Americans, might be somewhat dificult to comprehend. Most of us experience pain with a great deal of seriousness and attempt to avert if by using fast-relief measures, such as medication. The belief that food is a source of strength and healing is probably less alien to many. In the Jewish culture, chicken soup is highly regarded as a source of strength and healing. A number of jokes have even been made about the wonders of "Jewish penicillin." Another example of how food is seen as a therapeutic agent is the statement, "an apple a day keeps the doctor away." This saying is fairly commonplace in the United States, and it is known that in certain rural New England areas the daily consumption of apples is religiously adhered to.

One remedy that has always played a significant part in healing and prevention has been the use of a formula or prescription. Early American frontier medicine had its own formula for curing nightmares, which were considered to be a form of mental illness.

> Into a copper kettle, and five quarts of water, add one handful each of the bark of yellow poplar, dogwood, wild cherry, and yellow sarsaparilla. Boil to two quarts. Add one pint whiskey. Take one tablespoonful twice daily.[4]

In addition to the significance of the formula, the prescription in and of itself has also been valued by various cultures. Stories have been told about people

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in pre-revolutionary Russia who would travel miles to see the doctor to get a prescription, but they would never have it filled. So important and powerful was the written word that medication was not even considered necessary. Another nation, in which various cultural groups value the power of the written word, is Turkey. Ozturk found that Turkish patients had reverence not only for the religious writings of the Koran and the Bible, but also for the doctor's prescription.[5] These patients talk about boiling the prescription in water, then drinking the water, which is believed to absorb the curative power of the writing.[6] Imagine the response of a Western psychiatrist to either of these groups. On the one hand, a Russian patient would wish to carry the prescription around rather than to have the medication. On the other hand, the Turkish patient would want to boil the prescription and drink the water. Unless the psychiatrist has some transcultural understanding, he could be very bewildered and more serious to the point of this paper, he might impute psychotically generated behavior to these people.

Many culture-linked preferences are found even in the realm of scientific treatment. R.B. Davis discovered in India, depressed patients prefer ECT to the tricyclics.[7] This appears to be related to traditional Indian medicine which concerns itself with "hot" and "cold" aspects of the body.[8] For some reason, the tricyclics and phenothiazines are viewed as "hot" medicines and therefore rejected by depressed patients.[9] Additionally, ECT in India has less stigma attached to it, and a higher status, than in Western countries.[10] In the United States, depressed patients are aversive to and even frightened by ECT because it appears to be associated with having a higher degree of mental illness. The author has heard some depressed patients say, "Do you think that I am crazy and need shock treatments?" This kind of reaction is especially true of those patients who have not responded to the tricyclics or other types of treatment, including psychotherapy. Although Indian patients prefer ECT, especially when other therapies fail, Americans prefer medication. In this country, medication has a higher status and is much more accepted as a primary method of healing. Moreover, one medication may be favored over another. Although it has not been scientifically studied, the author has observed that a number of patients who come to the clinic, regardless of diagnosis and symptoms, request Valium. Valium has become the wonder drug of the decade and therefore the preferred choice of numbers of people.

**Physical Variations in Different Ethnic Groups**

In addition to being aware of the cultural variations of different ethnic groups, the clinician also needs to be knowledgeable about the physical variations among groups. This transcends any concept of physical superiority of one race over another; it implies an understanding, among other physiognomical differences, of the metabolic process. Such an understanding is essential, especially if medication is to be administered.

Denber, Bente, and Rajotte conducted a study that suggested genetic factors played a part in the dosage of medication required, and its side effects, in two cultural groups — Manhattan psychiatric patients and Erlanger Germany psychiatric patients.[11] This study showed that although the Manhattan group received a higher dosage of the medication, there were less side effects in the Erlanger group, which had received a lower dosage of the same medication.[12]

Alcoholic toleration is another illustration of metabolic differences in ethnic groups. The differences of why it took longer for American Indians, including Eskimos, to sober up after a drinking episode than whites, was studied by Fenna et al, who administered ethanol to these subjects and determined blood alcohol concentation at intervals.[13] Fenna found that the concentration fell significantly faster in whites, and since neither previous experience with alcohol, nor general diet appeared to account for the difference, genetic factors appeared the indicated cause.[14] Orientals are known to be highly sensitive to alcohol. In a study conducted with Japanese, Taiwanese, and Korean adults and infants, marked facial flushing and mild-to-moderate symptoms of intoxication were noted after alcohol had been consumed.[15] However, when the same amount was consumed by Caucasoids there was no detectable effect.[16]

**The Clinician's Biases and Personal Preferences**

The clinician's examination of his background, biases, and personal preferences is a difficult endeavor, especially when ignorance of cultural differences can result in an avoidance of analyzing certain prejudices. It is, after all, far easier to project one's mistakes and errors onto the patient rather than to accept the fact that cultural ignorance can effect clinical judgment. However, self-examination is especially important in the development of transcultural sensitivity. The author believes that there are three key areas on which a clinician should be particularly self-reflective. These are: diagnostic assessment, course of treatment, and clinical style.

A diagnostic evaluation requires careful and impartial judgment, and the clinician need be wary lest his objectivity be contaminated by personal bias. One study of note further illustrates how a diagnostic evaluation is influenced by an interviewer's cultural background, and in particular, the language factor.

Marcos Luis et al. noted the effect of language on interviewing, and concluded that Spanish-speaking schizophrenic patients disclosed more psychopathology when the patients were interviewed in the English language.[17] Such patients speaking in English may be tense, and "give up' their attempt to communicate, and therefore appear clinically more withdrawn and uncooperative.[18] However, the author has also noticed a similar kind of "giving up" even in Spanish-speaking patients whose English appears quite adequate. The author recalls a Puerto Rican schizophrenic patient, who actively hallucinating, anxiously requested to see a Spanish doctor because "only he can understand me." In an attempt to understand the importance of this patient's request, the author discussed the incident with a Hispanic colleague. The dynamics surrounding this are very complicated, but for this paper, a simplification of the processes is presented. A Spanish-speaking therapist and patient have in common a shared cultural understanding of religious and pseudo-religious experiences prevalent in that culture. In some situations, the patient will project onto the therapist attributes of a spiritualist as a healing person. This dialectic relationship implies fullest use of transference for both spiritualist (doctor) and patient. This kind of interaction suggests that patient will have less resistance to treatment and will project to the utmost on the grounds of transference based on shared cultural experiences. Transference becomes an important issue and if it does not exist, results are considered ineffective. Further, the patient requires reassurance and acceptance from another member of his own culture so that he will not feel alienated and ostracized from the culture at large.

The second area in which self-examination could bring improvement to the clinician's work is the course of treatment itself. In treatment, the choice of modality and medication is often determined by what the clinician prefers and feels most comfortable with. However, after a certain modality, with or without medication, has been chosen, attention needs to be given to its effectiveness. "Effectiveness" of treatment in this case is defined as a reduction or alleviation of the patient's presenting symptoms. At some time or another, every clinician is confronted with the fact that there are some symptoms that persist. Sometimes, this may alarm the clinician, and make him feel that he has not successfully treated the patient, with the result that he may reach into the "psychiatric grab bag" to institute treatment which may be far worse than the disease itself. A startling example of this is highlighted in a study by Sheppard et al. who administered a questionnaire to New York and California psychiatrists which described the symptoms of a thirty-four year old male middle class computer programmer with a history of marital difficulty, who was experiencing an acute paranoid break and was progressively deteriorating.[19] The treatment preferences were divided into: no drugs, single, and polypharmacy regimens.[20] The results of this study showed that as drug treatment became ineffective, polypharmacy escalated into maxipharmacy as the symptoms persisted.[21] The author empathizes with Sheppard's sentiments that the psychiatrist does not operate as a "free agent," but at the hands of society's expectation for a cure for mental illness. Every clinician at some time or another has experienced unrealistic expectations from both the patient and the society as a whole. However, caution should be exercised even though the pressures for results are paramount. Maxipharmacy is detrimental to treatment, but it is especially harmful to the field of transcultural psychiatry since it ignores how certain ethnic groups react to mediction. Thus, when a patient does not respond to a particular medication, or combination of medications, consideration should be given to other types of treatment or perhaps to no treatment at all.

The third area that requires the therapist's utmost attention is his clinical style. There are times when a therapist may have to readjust his usual approach. This is particularly true in transcultural treatment. John L. Cox has stated it quite well: Thus the treatment of a patient from a contrast-culture is a transcultural dyadic, and for communication to be meaningful the psychiatrist may need not only to understand his own prejudices, but also to accept certain modifications and limitations of his customary style.[22]

Of course, modifying his style involves more energy and effort on the part of the clinician, and often he may prefer to let the therapy run into a impasse rather than change his approach. However, if the clinician is willing to alter his style, therapy can take on a new, perhaps even more interesting dimension for both clinician and patient. A fine example of a clinician readjusting her clinical style to meet the needs of the patient is Louis Jilek-Aall, who, in her work with Canadian Indian patients, found that she had to abandon the traditional psychotherapy approach and instead use European fairy tales whose mythological aspects are similar to the Canadian Indian beliefs.[23] In addition, Dr. Aall studied the history, mythology, ritual, and social behavior of the local Indians and as a result, was invited to watch ceremonials and healing performances usually closed to non-Indians.[24]

## Rx for Transcultural Sensitivity

Transcultural sensitivity has vast implications for psychiatry and any health care delivery system. To acquire transcultural sensitivity the clinician must take initiative and make use of the professional educational system. All clinicians would do well to follow Dr. Aall's example of studying the culture thoroughly and applying the knowledge in treatment. a clinician can increase his knowledge by doing extensive reading about the cultural groups he treats. Additionally, most clinics and hospitals have professional staff of different ethnic groups, and the clinician could request supervision from his colleagues of these groups to further enhance his understanding of cultural ways.

Unfortunately, the professional schools of medicine, social work, and nursing have, for the most part, omitted transcultural education from their curriculums. Further, continuing-education courses and conferences have also devoted little attention to this important subject. A clinician's knowledge about transcultural issues is dependent not only on his own efforts, but also on availability of the education and training offered by the professional system. In addition, to some of the areas the author has discussed about healing preferences and physical differences among ethnic groups, curriculum and seminars should provide courses in the clinical issues of diagnostic categories, suicide, and in depth family studies. Beyond academia, sensitivity training in transcultural education should be implemented using role playing and psychodrama, or sociodrama techniques.

If today, we are striving to improve our delivery of health care, we cannot be indifferent to the issue of transcultural sensitivity.

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"Sacrifice can only be made for something greater than one's self."

Al-Tabib