Cultural Aspects of Consultation-Liaison Psychiatry

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Culture influences thoughts, emotions, and behaviors in individuals, groups, and communities, and thus it can have a significant impact on illness behavior and the practice of health care. Culture can influence disease through a variety of mediating factors such as diet, smoking, use of alcohol and other drugs, activity levels, and compliance with medical management. Increasingly culturally competent medical practice is the goal for psychiatrists consulting to patients of diverse ethnic or cultural backgrounds (Bigby 2003; Tseng and Streltzer 2008), The consultation-liaison psychiatrist should not only be aware of cultural aspects of the assessment of the patient but also of the consultation process itself. This chapter elaborates broadly on cultural aspects of consultation-liaison service, including: the process of referral; the nature of the clinical problems; the interview; and clinical management and liaison work.

11.1 Obtaining a Psychiatric Consultation: The Influence of Culture

Associated with the increase of medical knowledge in contemporary society, patients and families have become more familiar and comfortable with the work of psychiatry. However, perceptions by people of different cultural backgrounds vary about psychiatrists and their patients. In some cultures, the terms like "brain doctor" or "psychological doctor" are used to avoid negative connotations of "psychiatrist." This reflects culturally stimulated stigma.

11.1.1 The physician's Referral for "Psychiatric Consultation"

Before performing the consultation, it is desirable to know from the referring physician why psychiatric consultation is sought, how the referral has been explained to the patient, and how the patient reacted to the idea of psychiatric consultation.

For patients or families who have misconceptions about psychiatry, and equate psychiatric problems with psychosis or insanity, the primary physician's explanation about the need for psychiatric consultation is critical. If not done carefully, the patient might react negatively, interpreting that the physician was dismissing him or her as a "crazy" person, and then failing to cooperate with the consulting psychiatrist.

11.1.2 The consultant's Introduction to the Patient and Family

Ordinarily, the consultant will introduce himself or herself as a consulting psychiatrist, or simply a psychiatrist, or doctor, depending on the situation. The interaction and relationship that is going to develop with the patient is more important than the particular form of introduction. A relaxed, confident manner is far more likely to initiate a therapeutic alliance than a timid, apologetic tone, in which the patient may feel that he or she is being asked to put the consultant at ease.

11.2 Culture Influences the Exploration of Clinical Problems

Factors that shape the process of exploration of clinical problems include such things as the personality of the clinician, professional orientation and experiences, and the medical culture within which the service is provided. In addition, the cultural backgrounds of the patient and the physician are going to interact during the process of the clinical exploration and assessment.

11.2.1 The Dynamic Nature of the Patient's Presentation of Complaints

The presentation of complaints by the patient and the assessment of problems by the doctor occur as a process that is subject to various factors (Tseng 2001, pp. 446–449). On the patient's side, it starts with the experience of problems or distress, which is subject to the patient's personality,

personal background, and environmental context. The nature of the stress encountered is subject to the patient's perception of the stress and coping style. Finally, the presentation of the problems by the patient to others depends on additional factors including the patient's conception and understanding of the problems, motivation and expectations, and the patient's orientation about the care system and the physician, psychiatrist or other medical staff. The patient's presentation will then influence how the clinician interacts with the patient while making an assessment.

As for the clinician's side, the process of assessment and diagnosis will be influenced by the clinician's sensitivity, perception of a morbid condition, familiarity with the problems, and professional definition of pathology. Furthermore, the clinician is subject to the influence of professional training, choice of theoretical background, classification system utilized, and the medical culture within which he or she practices, in addition to clinician's personality and personal experience. In another words, clinical assessment is a dynamic process subject to impact of various factors, including social and cultural factors of both the patient and the clinician.

11.2.2 Understanding the Potential Gap Between "Disease" and "Illness"

The consultation-liaison psychiatrist needs to understand the potential conceptual gap between "illness" and "disease," a distinction related to professional and popular ideas of sickness (Eisenberg 1977).

The term "disease" refers to the pathological or malfunctioning condition that is diagnosed by a clinician. It is the physician's conceptualization of the patient's problem, which derives from the paradigm of disease in which the physician (including psychiatrists) was trained. For example, a biomedically oriented psychiatrist is trained to diagnose "mental disease," a pathological condition that can be grasped and comprehended from a medical point of view, providing an objective and professional perspective on how the sickness may occur, how it is manifested, how it progresses, and how it ends.

In contrast, the term "illness" refers to the sickness that is experienced and perceived by the patient and his/her family. It is patient's subjective perception, experience, and interpretation of his/her suffering. Although the terms "disease" and "illness" are linguistically almost synonymous, they are purposely used differently to refer to two separate conditions. It is intended to illustrate that "disease" as perceived by the physicians healer may or may not be similar to "illness" as perceived and experienced by the person in suffering. This artificial distinction is useful from a cultural perspective, because it illustrates a potential gap between the healer (physician) and the help-seeker (patient) in viewing the problems. Although the biomedically oriented physician tends to assume that "disease" is a universal and medical entity, from a medical anthropological point of view, all clinicians' diagnoses, as well as patients' illness experiences, are cognitive constructions based on cultural schema.

The potential gap between disease and illness is an area that deserves the clinician's attention in order to make the clinical assessment meaningful and useful, particularly in a cross-cultural situation.

11.2.2.1 The Cross-Cultural Consultation

11.2.2.1.1 Vignette

A Caucasian-American psychiatric consultant was called to consult on a 58 year-old, second generation, Japanese-American man, suffering from terminal stomach cancer. The consultant introduced himself, but before he could explain why he was consulting, the patient spontaneously reported that he had gone to Japan and received vials of a special injectable medicine to treat his cancer. He wondered if the consultant knew of this treatment and could help him take the formula correctly. The consultant expressed interest, but responded that he had no knowledge of such treatment. The patient was enthusiastic about this medicine and seemed to be in denial of his terminal illness (indeed, he died 3 weeks later). His wife was present during the session. At the end,

she asked to talk to the psychiatric consultant separately out of the room. She complained that her husband was driving her crazy and was also not relating on any meaningful level with their only child, a 19-year-old daughter, who felt quite alienated from him. The consultant assured her that he would be back to talk to her husband further. The next day the consultant met with the patient alone. The consultant focused the conversation on the family, and the patient stopped talking about his miracle cure. The patient acknowledged that his first priority was the well-being of his wife and daughter. It was for this reason that he was obsessed with a cure. He needed to regain his health, so he could continue to be the provider for his family. He was not good at expressing himself in words, and did not know how to relate to his family, other than by being a good provider. He was unable to communicate with his daughter, and it bothered him a lot.

The consultant helped him articulate his love for his wife and daughter, and then arranged a meeting so that he might have the opportunity to say what had always been unsaid, and to leave them with positive memories of him. The consultant agreed to be at the meeting to facilitate the discussion, which alleviated somewhat the patient's anxiety about such a conversation. The meeting began with tension, but soon the family members cried and hugged each other, and they talked at length. The positive feelings and open communication continued the next few days until the patient became too ill to talk. The family grieved without ambivalence when he died.

Denial is often useful in medical illness, and in terminal disease. It is compatible with some cultures including Japanese, and tends to be fostered by the family and the doctors. In this case, however, there was much unfinished business within the family. For the dying process to be successful, the patient needed to feel that he was leaving the family with good memories of him, a positive legacy. The family needed to resolve their anger and disappointment with the patient.

This case has been described in great detail as an example of a psychotherapeutic intervention by a consultation-liaison psychiatrist (Streltzer 2001). Cultural issues were involved at several levels. The alternative treatment of the Japanese cure turned out to be a superficial issue covering more meaningful concerns. The patient was the provider but not the manager of the family, a traditional role for a second-generation Japanese man. The wife had acculturated more to the host culture, and was more "liberated" in philosophy, but not to the point that she could directly confront her husband. The "cultural gap" between the patient and the consulting psychiatrist allowed the psychiatrist to serve in effect as a "cultural broker" to resolve the conflict.

11.2.2.2 Culture-Related Mind–Body Issues

A cultural perspective is particularly helpful in understanding the clinical ramifications of beliefs about the mind–body relationship. Often unaware of the philosophical implications, Western physicians commonly view the issue in dualistic terms, body and mind conceptualized as separate, dichotomized things. Closely associated with this epistemological view is the notion that it is more mature or superior to express psychological problems through psychological complaints rather than somatic complaints. Eastern medical philosophies do not necessarily hold the same view. By viewing body and mind as integrated parts of a whole being, they do not distinguish distinctly between them, and do not try to view psychological or somatic manifestations in a hierarchical way. For many cultures, people learn how to express their emotions through language pertaining to the body.

11.2.2.3 The patient's History of Self-Management: Utilization of Indigenous and/or Traditional Remedies

The consultation-liaison psychiatrist may want to explore the patient's and family's folk concept of sickness and history of possible utilization of indigenous and/or traditional remedies. Patients from both Eastern and Western cultures, developed modern societies and undeveloped traditional societies, use traditional remedies to try to heal their medical condition. They often do not inform their physician about their use of

traditional remedies, because they may believe that it is a separate matter. It may not be so separate, however, as in the case of drug interactions between modern and traditional medicine, for example. They may hesitate to reveal that they are using indigenous healing methods, concerned that the modern physician will look down upon their behavior. The consultation-liaison psychiatrist needs to gently ask if traditional and modern treatments are being utilized simultaneously by the patient.

11.3 The Interview Process

In order to carry out culture-relevant and competent clinical assessment, there are several issues that deserve attention. It starts with how to maintaining culture-appropriate physician–patient relationship.

11.3.1 Culturally Appropriate Physician–Patient Relationship

Most consultations are not initiated by the patient, and, therefore, rapidly building rapport is a special skill extremely desirable for the consultation-liaison psychiatrist. The relationship is itself a therapeutic tool and the outcome of the consultation may vary significantly depending on the quality of this relationship. This is particularly true with patients of different cultural backgrounds from the consultation-liaison psychiatrist.

An important perspective can be seen by examining contemporary American culture. In the medical setting, the predominant form of physician–patient relationship is egalitarian, based on an implied contractual agreement between the two that is influenced heavily by an ideological emphasis on individualism, autonomy, and consumerism. In contrast, in many traditional Asian cultures, there is more emphasis on an ideal form of hierarchical relationship. The physician is seen as an authority figure who is endowed with knowledge and experience. An ideal doctor should have great virtue and be concerned, caring, and conscientiously responsible for the patient's welfare. In return, the patient must show respect and deference for the physician's authority and suggestions. This respect and deference may inhibit the patient from asking questions and discussing choices and alternatives.

The psychiatric consultant has the task of rapidly developing a working alliance with a patient who usually did not request the doctor's services (see Chapter on Interviewing). This task is all the more difficult if a cultural gap exists between them. Bridging this gap may become critical to gaining rapport, making a correct assessment, and engaging in therapeutic interventions. One should not assume that having an ethnic or cultural mismatch with the patient is a disadvantage. A patient may feel less likely to lose face to an outsider, who may be perceived as less judgmental and more accepting. The doctor may also plead ignorance of the patient's background, expressing an interest in learning about it. This may promote a connection with the patient (Tseng and Streltzer 2001).

When cultural issues are suspected at all, the patient should be encouraged to explain his or her culture, in essence becoming the cultural guide to help the doctor put the issue into proper cultural perspective. The objective is to demonstrate to the patient that one's concerns are synchronous with the patient's interests. This increases the chances of developing a working relationship quickly.

Such communication works best when there is a shared language. If there is not, interpreters are often required, and cultural differences are more difficult to overcome.

11.3.2 Culturally Appropriate History-Taking

The interview is the major aspect of psychiatrist-patient interaction. How the patient presents complaints and informs the consultation-liaison psychiatrist of his or her problems and how the psychiatrist, reciprocally, listens, asks questions, and provides relevant explanations to the patient are key areas of communication that closely relate to the achievement of meaningful and effective clinical service.

From a cultural point of view, the clinician should judge to what extent the patient is familiar with the psychiatric interview, and provide explanations if necessary for those who feel unfamiliar with this type of communication. Whenever appropriate, the interviewer should ask the patient whether he/she identifies with his/her ethnic or parental culture. If the patient does, it would be a good idea to tell the patient to let the interviewer know if some of the questions or discussions touch on culturally sensitive areas. The interviewer should then use an active style to obtain basic information needed for assessment of "disease," but make sure that the patient is given the opportunity to communicate concerns and problems from the perspective of "illness." The ability to skillfully intertwine these two interview styles is an indication of competence from a clinical as well as a cultural perspective.

Although it is desirable for a patient to communicate freely about his or her personal background, illness history, and other related information to the consultation-liaison psychiatrist, this does not always happen in clinical situations. The patient's ability to describe things and willingness to communicate are often influenced by clinical condition, motivation, and understanding of the purpose of doing so. In addition, there is a cultural impact on the process of problem communication.

Emotional problems and personal feelings are generally considered highly private matters, not to be revealed to strangers. In many cultures, doctors are exempt from this prohibition, but there is variation. In some cultures, talking about one's inner feelings is almost as taboo as parading nude in public. Family conflicts are often regarded as "inside" problems that should not be revealed, even to a doctor.

11.3.3 Culturally Relevant Mental Status Examination

As a part of the initial diagnostic interview, the consultation-liaison psychiatrist will often perform a formal mental status examination. The contemporary method of mental status examination taught to the medical students or psychiatric residents is derived from clinical experience with Western patients, mostly with American patients. However, it may not suitable for patients of other cultures, and may need to be modified (Tseng 2003, pp. 231–232).

For example, asking "Do you hear any voices?" may not be understood by the patient as inquiring into the presence of auditory hallucinations. Instead, he/she may answer that his/her hearing ability is intact. This caution is needed for all patients, particularly those who are unfamiliar with psychiatric terms and concepts, and especially those whose cultural backgrounds include few experiences with psychiatric jargon. "How do you feel?" "Are you depressed?" are other examples of questions that sound simple in daily English, but can be very confusing from the language and conceptual perspectives of those who use language without referring to "feeling" or states of "depression." Questions such as "Do you feel tired? Do you have the energy to do daily work? How is your appetite for eating? Do you have interest in your daily activities?" may be more suitable to ask.

As a part of the mental status examination, clinicians often ask questions such as "Who is the President of the USA?" to examine the patient's level of general knowledge. This is a proper question to ask if the patient is a citizen of the USA with adequate contact with the social environment through news media. However, failure to answer such a question means little when it is addressed to a foreigner or someone who hardly ever has access to social media.

When communication is difficult, as is more frequently the case when there are cultural differences, a clinician may wonder if a thought disorder is present. A psychiatrist may choose to ask for proverb interpretations to test abstracting ability. Proverbs, however, are a cultural product and their interpretations are subject to cultural influence. The commonly used proverbs, "A rolling stone gathers no moss," or "The grass is greener on the other side of the fence," for example have their roots in British language and culture, and are foreign to the point of meaninglessness to many non-Westerners.

Asians and others may use their own proverbs to express certain issues that may or may not be familiar to the Westerners. For example, a Japanese proverb is "Even *kappa* (a legendary animal good at swimming) would drown in the river," a Chinese one is "Monkeys will fall from trees." Interestingly, a German proverb is "The best swimmer drowns first." These proverbs have the same basic meaning, yet are expressed in different ways. However, some proverbs are culturally unique. For instance, a Korean proverb says: "After 3 years, even a dog in school will learn how to bark poems" implying the virtues of persistence and diligence. A Japanese proverb says: "Fortune is contained in the leftover (food)," suggesting that a person should not compete with others. These proverbs may be entirely unfamiliar to other cultures.

A useful technique to determine if a proverb is culturally appropriate is to ask the patient if he or she has ever heard that proverb or old saying. If the patient has heard of it, but still fails to abstract it, the information is potentially useful. Somewhat culturally universal proverbs include, "Don't judge a book by its cover," and, "Don't count your chickens before they hatch."

11.3.4 Use of Interpreters

Problems of communication between consultation-liaison psychiatrist and patient are highlighted when the consultation-liaison psychiatrist and the patient do not share the same language and have to rely on the assistance of interpreters to communicate. Who serves as the interpreter, whether a close family member, a friend, a member of the same ethnic group, or a trained interpreter with mental health knowledge and experience, will affect significantly the process and quality of translation and interpretation. Proper translation that is relevant and meaningful for clinical purposes is difficult to achieve (Tseng 2003, pp. 231).

Selecting the proper interpreter and utilizing the interpreter to effectively communicate with the patient during a psychiatric consultation is a matter of clinical skill and art. Ideally, an interpreter trained to work in medical or mental health settings is employed. There are several different ways to use an interpreter, namely: word-for-word translation is needed for areas that are delicate and significant; summary translation for areas that require abstract interpretation; and meaning interpretation for areas that need elaboration and explanation in addition to translation. By coaching the interpreter in these different styles of interpretation, the process will be more efficient and useful.

In a consultation setting, sometimes a family member is visiting the patient and may be capable of interpreting. There are pros and cons when a family member is the translator. The bilingual relative will have been acculturated to a greater or lesser extent and may be able to provide insight into the cultural factors influencing the patient's behavior, motivations, and expectations. On the other hand, if the psychiatric assessment involves complicated personal emotional issues or delicate interpersonal or family matters, the family member may perform one of the common translation errors: deletion or omission of information, distortion of meaning, exaggeration or adding of information. The consultation-liaison psychiatrist should be sensitive to the possibility of bias affecting the translation, as well as a reluctance on the part of the patient to be forthright because of the lack of confidentiality or because of an anticipated reaction from the relative.

Sometimes, a member of the hospital staff is available as a translator, such as a nurse, or nurse's aide. If this person is medically knowledgeable, and experienced as an interpreter this may work out very well. This is not always the case, however, and even if the person is not a relative, he or she may be a member of the patient's same community. The patient may not reveal a reluctance to speak in front of this person, or the cultural expectations of this interpreter may distort the translation.

In general, the interpreter needs orientation, and perhaps training, for the work that is to be done.

11.4 Culture and Consultation-Liaison Psychiatry

11.4.1 Respecting Culturally Suitable Privacy and Confidentiality

The concept of privacy and confidentiality varies greatly among people of different cultural backgrounds. For cultures that emphasize the importance of individuality, as exemplified by the USA, medical practice tends to respect the privacy of individual patients as much as possible. Physicians have the professional and ethical duty to keep medical information confidential, not revealing it to others, even the patient's parents, spouse, or other family members, without permission from the patient. In contrast to this, for cultures that value family and interdependence more than individual autonomy, parents may demand that physicians inform them about the medical condition or problems of their adult children. Similarly, a spouse may expect medical information to be shared about their marital partner. Protecting individual privacy and confidentiality, but at the same time, not defy the cultural expectation of sharing information within the family, or even the relatives or friends, is a challenge for the consultation-liaison psychiatrist.

11.4.2 Breaking the News: Informing the Patient and Family of the Diagnosis

Another important and delicate issue is how to inform the patient and family of the medical diagnosis. In Western Europe or North America, following contemporary medical practice, a physician often openly and frankly informs the patient of the diagnosis of the disorder from which the patient is suffering, even when the news is ominous and expected to be frightening to the patient. Otherwise, the physician would fear a malpractice suit.

However, in contrast, in many societies, such as Japan and other East Asian societies, it is normal for a physician to conceal the actual medical diagnosis from the patient, particularly of a serious or fatal illness, to protect the "vulnerable" patient. (This was a practice also common in the USA prior to the 1960s) The actual diagnosis is told only to the family. If the physician were to reveal a potentially fatal diagnosis to the patient without the family's consent, he or she may be subject to resentment from the family. This is a complex matter, in which the physician needs to act according to proper medical ethics as well as the culture of the society.

11.4.3 Family Involvement

Involving the family in the patient's medical care, including examination, assessment, and even treatment, will be particularly challenging to clinicians in Western societies. The consultation-liaison psychiatrist sometimes has referrals generated primarily because the primary physician is uncomfortable dealing with family members who are attempting to be actively involved in a patient's care. It is almost impossible to exclude the family in cultures that are very family-oriented (rather than individually oriented), such as is common in Eastern societies. Based on clinical experience, we know that involvement of the family in an interview sessions has both advantages and disadvantages.

Among the advantages, in addition to relieving the family's anxiety, is the enabling of the clinician to obtain needed collateral information to assist in the process of assessment, and to provide an opportunity for the interviewer to observe how the patient and family interact. Working with the family increases their ability to support the patient's recovery.

Disadvantages are that family involvement may discourage the patient from expressing personal concerns or communicating about family conflicts. This is also true in reverse, with family members hesitant to express concerns about the patient in front of the patient. Therefore, it is sometimes best to approach the patient and family separately at some time during the interview process.

From a cultural point of view, however, family can serve not only as a resource for collateral

information but also as a base from which to check cultural reality. Unless major family pathology is present, the consultation-liaison psychiatrist can obtain from the family members a culturally objective indication as to what extent the thoughts and behaviors manifested by the patient are normal, unusual, or deviating from the sociocultural norm. The interviewer also can learn culturally relevant coping techniques available to the patient to resolve problems. Generally speaking, family involvement is helpful to the process of liaison work. This is particularly so for patients with a strong family-oriented background.

11.4.4 Ethnic Consideration for Recommendation of Medication

Modern Western medicine is based on a technology that prepares drugs in pure abstract forms to perform specific pharmacological functions. Modern physicians usually prescribe a single medication for a specific purpose, and for multiple problems they may prescribe multiple medications. Usually the least number of medications possible is considered to be the goal. In contrast, herbal medicines used in traditional medical practice are thought to work by combining multiple remedies in their raw forms. Multiple herbs are always prescribed, as there is not too much concern over combining medications. In general, in societies where traditional medicine is still used, Western medicine is considered "strong" and useful for combating the specific etiology of a disorder, but there are usually unwelcome side effects. Traditional herbal medicine is viewed as "harmonious," with fewer side effects, and will "strengthen" the body so that it can overcome the disorder, or not get it in the first place.

Modern Western physicians make no secret about the name and nature of prescriptions, and often make it a goal to explain to the patient the drug mechanism as well as potential side effects. Traditional physicians, on the other hand, sometimes keep prescriptions "secret" and in some Asian countries, such as Japan, China, and Korea, the patient may not expect or desire the physician to give a full explanation.

Associated with this is the tendency of patients to feel that there is no need to follow the physician's orders in taking the medication. If the medicine works immediately (within a day or so), the patient will take it. If the symptoms subside, the patient may feel no obligation to continue the medication, even when directed by the physician.

Beyond psychological issues relating to prescribing and receiving medication, there are also biological issues as well. There are potential ethnic differences in the pharmacokinetics and pharmacodynamics of drugs that are used. In general, Asian patients and patients of some other ethnic/racial groups need smaller doses than textbook recommendations, which are based on studies of Caucasians.

11.4.5 Communication to the Referring Physician and Staff

The consultation-liaison psychiatrist communicates to the referring physician in several ways. For uncomplicated consults, a note in the chart may suffice, but direct communication is usually preferable. Increasingly, clinicians are becoming sensitive to cultural issues, and they are likely to be interested if the consultation-liaison psychiatrist discusses cultural issues as part of the recommendations for care.

Case example: An internist known to be rather autocratic asked a consultation-liaison psychiatrist to see his patient to determine if he needed to be committed to a mental hospital. The patient was a Russian immigrant who had been working as a radiology technician. The patient was in his final few days of intravenous antibiotics for a cellulitis. The patient, a diabetic, had been arguing with the nurses about his insulin doses. The psychiatrist discovered that the patient was a physician who had not been licensed the USA. He had always managed his diabetes without difficulty and was rather obsessional about how it should be done, and about his need to care for himself.

The consultation-liaison psychiatrist reported to the internist that the patient was not committable to a psychiatric facility.

In this case, the patient was a Russian man, brought up in a society where his status as a physician made him an authority, well respected and valued for his competence and self-confidence. In addition to personality factors, the patient's demanding behavior could be partly explained on the basis of a cultural need for self-management. This formulation allowed the consultation-liaison psychiatrist to suggest that, since the patient had never demonstrated difficulty, why not let him have more say about his insulin dosing? The internist was able to comfortably relax his control of the diabetic management by viewing this as culturally appropriate, and the rest of the hospital course passed uneventfully.

11.4.6 Some Specific Clinical Issues

The variety of clinical issues encountered by consultation-liaison psychiatrists is endless. Some of them are heavily related to culture and deserve to be mentioned.

11.4.6.1 Culturally Stigmatized Medical Diseases

Because of their poor prognoses and historically limited effectiveness of treatment, the diagnoses of certain medical diseases still carry substantial stigma, despite an improvement in medical management. Leprosy, pulmonary tuberculosis, epilepsy, and venereal disease, as well as mental disease, are some examples of diseases that are still associated with strong negative views as a result of cultural beliefs, which intensely influence patients' emotional lives as well as their illness behavior. The patient's and his or her family's medical knowledge has an impact on attitude toward various kinds of disease.

11.4.6.2 Sex-Related Medical Conditions or Issues

There are certain medical disorders that are perceived as sex-related and, in turn, subject to cultural interpretation and reaction. For example, breast cancer is one of them. The varying degrees to which female breasts have a sexual role in different cultures may influence the patient's understanding of the causes of breast cancer. Concerning attitudes toward risk factors for breast cancer, there have been two broad cultural models. The Anglo-American model emphasizes family history and age as risk factors. The Latin model associates breast trauma and "bad" behaviors (such as alcohol and illegal drug use) as risk factors for breast cancer. This reflects a moral framework within which disease is interpreted.

Pregnancy and giving birth are not only major events in the parents' lives but they also have substantial cultural significance and are impacted by cultural beliefs. For instance, when the ideas and experiences of pregnancy and childbirth of Asian and non-Asian women in east London was compared, it was revealed that, although Asian women demonstrated a strong commitment to Western maternity care, they continued to follow traditional cultural practices such as observing a special diet in pregnancy and following restrictions on certain activities in the post-partum period. Asian women tended to want their partners present at delivery and to express a greater concern with the gender of the child.

In some ethnic groups, great attention is paid to post-partum care. In traditional Chinese belief, a woman is expected to observe 1 month of confinement after giving birth. She is not allowed to go outside of her house, to take "cold" foods (such as fruits), or to bath or even wash her hair. A woman is supposed to eat a lot of "hot" foods (such as chicken cooked with sesame oil and ginger). These customs were observed in the past, perhaps to prevent post-partum infection, and are still faithfully observed by some traditional women. In Micronesia, a traditional "pregnancy taboo" requires the wife to return to her family of origin once she discovers she is pregnant. She does not return to her husband's house until her child is old enough to hold his or her breath under water or to jump across a ditch, activities that ensure a greater likelihood of survival.

Breast-feeding is a very natural way to feed a newborn baby. However, despite the widely acknowledged evidence supporting the benefits of

breast-feeding (fewer childhood infections and allergies), the prevalence of breast-feeding in Western countries remains low. This may be due to the development of baby formula or time demands on a working mom. However, the cultural notion of the female breast as a primarily sexual object places the act of breast-feeding in a controversial light and can be one of the most influential factors in a woman's decision not to breast-feed.

In many cultures, reproduction is considered one of the major functions of women, and losing the uterus is considered to be losing the power of being a woman. Many women fear a change in sexual desire after a hysterectomy, and that their husbands will not want them because they are "incomplete" women. As a result, they might refuse to have their uteruses removed, or develop anxiety and depression after a hysterectomy.

Although menopause is a biological phenomenon, the intensity of menopausal symptoms varies among ethnic or racial groups. This may be due partially to diet, with a recent study revealing that Asian women may experience fewer hot flashes because of estrogen derived from soybean products in their meals. To what extent sexual attitudes contribute to emotional adjustment or attitudes toward menopause is a subject that requires future investigation.

11.4.6.3 Culturally and Ethically Controversial Medical Practices

Many medical practices are culturally proscribed, or prescribed, and are often as a result, ethically controversial. Following are some of the examples:

Artificial abortion is the subject of an intense emotional, political, and ethical debate in many countries. In the USA, there is no foreseeable resolution to the conflict, which has involved radical acts such as the bombing of abortion clinics and the shooting of physicians who perform abortions. However, in many countries, abortion is an accepted and uncontroversial part of family planning. This is particularly true where there is societal acceptance of the concept of population control. Thus, abortion is not merely a medical choice, but also a social, cultural, and political matter.

From a medical point of view, sterilization is a simple surgical operation and a way of family planning. However, there may be a significant psychological impact depending on how the procedure is seen by the patient's culture. In some cultures, particularly those that strongly emphasize the need for many children, sterilization can be most unwelcome. In such cases, sterilization for men may even be considered nearly equal to castration, even though medically it is not.

Whether physicians are allowed to offer active assistance for patients to end their lives is a controversial subject in many societies. In Holland, euthanasia is actively practiced by physicians. In Germany, assisted suicide is a legal option, but is usually practiced outside of the medical setting. In almost all of the USA, withdrawing from or refusing treatment is the only means currently permitted by law, and then only with legal documentation from the patient or his or her family.

It is important that the consultation-liaison psychiatrist know that medical practices developed by physicians for treatment of disease may be perceived and reacted to in various ways by patients and families not only because of personality-specific factors but also because of cultural background. This is the foundation for providing a culturally competent consultation service.

11.5 Medical Culture

In addition to cultural issues associated with patients and with staff, the consultation-liaison psychiatrist should recognize the presence of a medical culture that determines the manner in which care is provided (Tirrell 2001). Effective communication between doctor and patient requires an alignment of the medical culture with the cultural perpective by which the patient views the world and puts his or her illness in context.

For example, role expectations differ for patients with acute or chronic illness (Streltzer l983). The hospitalized acutely ill medical patient is expected to be a passive recipient of care. Diet, bathroom privileges, and all activities of daily living are prescribed by the doctor and taken care

of by others. In return, the patient is relieved of personal responsibilities, such as work, household chores, childcare, even personal grooming. By this tradition, the patient does not interfere with a doctor's treatment, and the patient is content because he or she usually gets better and resumes normal activities.

With chronic illness, however, the patient is expected to become responsible for accepting and managing the illness. An example is the diabetic who monitors glucose and adjusts insulin levels. Essentially the message is, "You are responsible for your illness: become educated about it and learn how to take care of it." Sometimes, however, the physician manages the chronic patient with an acute model. The message from the physician becomes, "You are responsible for your illness and activities, but at the same time you must do exactly as I say with regard to the medical management of your illness." For some patients, these two messages are difficult to resolve, leading to conflict, misunderstandings, and noncompliance (Alexander 1976). When this occurs, a psychiatric consultation is often requested. Factors associated with the medical culture can interact with the the patient's, as well as the physician's, cultural background, and should be taken into account.

11.5.1 Vignette

A 62-year-old man, treated with maintenance hemodialysis for 2 years, who threatened to kill the head nurse of his outpatient dialysis unit. He was a Caucasian-American retired cook in the merchant marines. The head nurse had emigrated from the Philippines 15 years before. She had a distinct but understandable accident, and she had a reputation for being very efficient and competent technically.

One day, seemingly out of the blue, the patient, who rarely talked much, finished his dialysis, then walked up to the head nurse, and said that he would come after her one day, and kill her. Although the head nurse did not take the threat seriously, other staff did. The unit manager phoned the psychiatric consultant asking for advice, adding that the patient refused psychiatric consultation. The consultant stated that in this situation he needed to see the patient despite his refusal, and asked that the patient be informed that he would be coming at a designated time.

The patient anticipated the visit of the psychiatric consultant and immediately spoke of his concerns. He was certain that the nurses were tampering with his dialysis machine when he was looking the other way. Possibly, they planned to put sugar water into his machine. The nurses, on the other hand, had reported that the patient often fell asleep during his dialysis.

In this unit the patients had all learned self dialysis. The nurses only helped the patient on and off of their machines, and were present in case there were problems during dialysis. In the case of this patient, they had begun watching his machine more closely as he often fell asleep and they found that his settings were often not ideal. When he woke up, he realized he had not been monitoring the machine. He suspected that he was being drugged. He came to the conclusion that the head nurse was trying to kill him, because of her presumed prejudice against Caucasians.

The psychiatrist assured him that he would talk to the head nurse, and also to the chief physician in charge, and make sure that no harm come to the patient. Furthermore, he would monitor the situation himself. The patient then discussed his life in response to the psychiatrist's interest. Raised in foster homes, at 13 he ran away and lied about his age to join the merchant marines. He became a cook, kept to himself, and was a heavy drinker. Kidney failure forced him to retire a few years ago. He married late in life, had no children, and did not socialize.

He had learned early on, that one must take care of himself because no one will do it for you. He liked to work independently of others, which he was able to do as a cook. He feared being dependent on others for dialysis, and had learned self dialysis. He demonstrated mild cognitive deficits along with paranoia on the mental status examination. The psychiatrist thought he was mildly demented and probably making mistakes in his dialysis without realizing it.

The psychiatrist placed him on 0.5 mg of haloperidol nightly, and arranged for his transfer to a dialysis unit where the patients were not required to dialyze themselves. He explained this to the patient in terms that allowed the patient to feel in control. The patient was satisfied and caused no problems in the new unit.

In this case, the patient had a chronic illness and the medical staff wanted him to be in charge of his own care as much as possible, simply making up for his deteriorating memory whenever needed. Because of his paranoid personality style and developing dementia, however, he misinterpreted their help in projected the blame for his own failings onto them. It was now necessary to structure his medical care and expect less from him, while presenting the changes in a way compatible with his personality style.

An important area where medical culture comes into play is the interpretation of somatization. Historically, somatoform symptoms in Western culture tended to be seizures, twitches, and paralyses until the twentiethcentury, when these symptoms became less common, replaced by chronic fatigue and pain (Shorter 1997). In medical practice, the somatizing patient can cause the practitioner to pursue an exhaustive and fruitless search for underlying medical pathology. The practitioner can be confused or even angered by the patient whose complaints do not conform to the expectation that that they must be stimulated by a somatic cause. All of this is consistent with the Western conception of mind–body dualism (Tseng 2001). Eastern cultures tend to have a more holistic conception of mind and body, and somatic complaints are often thought to have communication intentions and are not resistances to psychological issues, which may readily come to light if the doctor is sensitive enough to look for them. Somatization can have multiple implications, including being a culturally coded expression of distress, and being a mechanism for patients to negotiate their status in a medical context (Kirmayer and Young 1998). Somatization can reflect aspects of the underlying societal culture, and the corresponding medical culture may be consonant with this, but it also may not be. If the medical culture seems too alien to the patient, the patient may seek some sort of alternative healing.

11.6 Culture and Pain

Culture is known to influence the experience of pain, be it acute, chronic, cancer-related, or experimental (Green et al. 2003). Perhaps the best-known cross-cultural study of chronic pain is that of Zborowski (Zborowski 1952). He compared the responses of different ethnic groups to chronic pain by observing them in the hospital. He concluded that "old Americans" tended to be stoic and uncomplaining about their pain. In contrast, Italians and Jews readily voiced their complaints. He described the Italians as being present oriented, wanting immediate relief, whereas the Jews were future oriented, not wanting the pain to be taken away by medication, in order to monitor how their condition was doing. This study provided no data, not even the numbers of patients observed, however. No mention was made of the types of pain, the duration, the medications used, or concomitant psychiatric and medical conditions. It was even stated that not all patients fit these stereotypes! More sophisticated recent studies demonstrate how difficult it is to sort out the role of ethnicity because of many confounding factors.

A study that used multiple regression to sort out the influence of different factors on the management of pain found that ethnicity was a highly statistically significant variable, but accounted for at most 6 % of the variance (Streltzer and Wade 1981). It is reasonable to conclude that culture influences pain management, but not a great deal. Nevertheless psychosocial and cultural factors are clearly important in individual cases, even if generalities are difficult to make.

Perhaps even more importantly, the prevailing medical culture greatly influences the treatment of painful conditions. For example, the relationship of low back pain to physical findings explaining the pain and the related psychosocial dysfunction varies substantially by country (Sanders et al. 1992). Some of this may be directly related to culture of the society, and

some of it may be related to the medical care system, including the presence of entitlements for disability.

11.6.1 A Culture of Chronic Pain Management

In recent years, a pain management culture has influenced American medicine and that of some European countries. It may be considered a culture because it has specific values, beliefs, and practices with regard to the use of opioids for chronic pain. It minimizes or discounts and scientific evidence that does not conform to this belief system.

This new pain management culture developed as a reaction to the undertreatment of acute pain that was prevalent during the 1960s and 1970s in the USA, which itself probably was a reaction to the epidemic of drug abuse at the time (Marks and Sachar 1973). As this undertreatment became recognized, developments led to greatly improved management of acute pain and terminal pain, utilizing such technologies as epidural and patient controlled analgesia.

Chronic pain patients were known to have very different characteristics, however, and psychological and behavioral factors were recognized as extremely important in the development and maintenance of chronic syndromes. Pain clinics that usually required detoxification from dependency producing drugs developed to care for these patients, and they reported success (Malec et al. 1981).

Then in the mid 1980s, it was suggested that patients with chronic pain could do well if maintained on opioids. Cases appeared in the literature briefly described, usually on low maintenance doses of opioids (Portenoy and Foley 1986). This ushered in a new approach to chronic pain in the 1990s, involving chronic opioids, which were used in increasingly higher doses. Problematic cases began being seen in ever greater frequency by consultation liaison psychiatrists (Streltzer 1994).

Pain medicine became a subspecialty in its own right. In the USA, this subspecialty was originally certified only by the American Board of Anesthesiology beginning in 1993, but in recognition of the complexity and frustrations in treating chronic pain patients, the subspecialty became multidisciplinary in the year 2000, with certification available in physical medicine and rehabilitation, psychiatry, and neurology, as well as anesthesiology.

A review of opinions from the medical literature, Internet discussion groups, pain societies, and patient advocacy groups in the USA reveals a firm belief that opioids are efficacious analgesics even when given chronically on a daily basis (Streltzer 2000.). This belief requires that one accept a number of other propositions to be consistent. One such belief is that tolerance does not occur in the face of pain, or at least only to a certain point, and that higher doses mean that there is more pain, not that the opioids are losing their effectiveness. If pain becomes a problem again, the solution, therefore, is to raise the dose, or switch or rotate to another opioid. There is said to be "no upper limit" to opioid dose, and consequently maintenance with ultra high doses of opioids is being increasingly seen in problem patients referred to the consultation-liaison psychiatrist, usually after a period of several years of escalating doses.

Scientific evidence is weak in support of these beliefs, however, and in fact there is much evidence contradicting them. In particular, chronic opioids result in a cascade of cellular adaptations, such that physiological responses chronic opioids are quite distinct from responses to acutely administered opioids. The chronic adaptation includes tolerance, hyperalgesia, and probably craving, all by different distinct mechanisms. Thus, chronic opioids actually enhance sensitivity to pain, let alone induce tolerance to analgesia (see pain chapter) .

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