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Culture, Psychiatry and Cultural Competence

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1. Introduction

Why the study of culture and its clinical application is important in mental health training and service? Mental health and illness is a set of subjective experience and a social process and thus involves a practice of culture-congruent care. Series of anthropological, sociological and cross-cultural research has clearly demonstrated a very strong ground in favour of this contention.

An individual's cultural background colours every facets of illness, from linguistic or emotional expression (Helman, 2007; Lewis-Fernandez, 1996) to the content of somatic complaints (Goldber & Bridges, 1988) and delusional (Yip, 2003) or hallucinatory experiences (Kim, 2006; Cowen, 2011). Cause, course and outcome of major psychiatric disorders are influenced by cultural factors (Kleinman, 1988; Kirmayer, 2001; Littlewood & Lipsedge, 1997). Wide variations in the prevalence of many psychiatric disorders across geographic regions and ethnocultural groups have been documented (Maercker, 2001). In mental health, dysfunctional behaviour is a key issue in diagnosis, viz. distinction from normal to disordered behaviour. The social and cultural context here is important because identification of abnormal dysfunctional behaviour is basically a social judgement (Kirmayer & Young, 1999). Different cultural and ethnic groups have different perception and practices about health as per their ecocultural adaptation (Weisner, 2002). Social and cultural factors are major determinants of the use of health care services and alternative sources of help. Recent changing global demography demands the recognition and response to cultural diversity in psychiatric practice (intercultural clinical work). Culturally based attitudes and assumptions direct the perspectives that both patient and clinicians constantly encounter in therapeutic communications (Moffic, 1983).

Ethnicity, ethno-cultural identity, social class, cultural dimension of gender, cultural explanation and meaning of sufferings or illness, cultural codes of expression of distress, cultural value system and support network, cultural belief about religion and spirituality, cultural specificity in coping mechanism and ways of inter-cultural assimilation are the few broad issues in cultural psychiatry that helps to understand the clinical manifestation of psychopathology. Lack of awareness of important cultural differences can undermine the development of a therapeutic alliance and the negotiations and delivery of effective treatment. Following is a brief discussion on three important issues, viz. relationship between culture and mental health, cultural competence and cross-cultural communication and lastly the outline of cultural formulation in clinical assessment.

2. Cultural psychiatry

“Psychiatry may outline a science of the psyche and its disturbances but it also reflects a cultural interpretation about personal experience, responsibility, social behaviour, and the requirements for social order. The cultural character of the psychiatric enterprise itself, just as much as the characteristics of its disorders, constitute the subject matter of cultural psychiatry” (Fabrega, 2001).

2.1 Cultural psychiatry: Definition and concept

It is a special field of psychiatry concerned with the cultural aspects of human behaviour, mental health, psychopathology and treatment (APA, 1969). Alarcon (2009) puts it as: “Cultural psychiatry deals with the description, definition, assessment, and management of all psychiatric conditions, inasmuch as they reflect and are subjected to the patterning influence of cultural factors. It uses concepts and instruments from the social and biological sciences, to advance a full understanding of psychopathological events and their management by patients, families, professionals and the community at large.” Within the framework of bio-psych-socio-cultural paradigm in psychiatry, cultural psychiatry is mainly focused on socio-cultural aspects of human behaviour. Tseng (2001) proposes three levels of approach: **Clinical level:** that aims to promote culturally competent mental health care for patients of diverse ethnic and cultural backgrounds, viz., culturally relevant assessment and culturally appropriate care. **Research level:** is the exploration of how ethnic or cultural factors influence behaviour and psychopathology as well as the process of healing (ethnopharmacology) and at **Theoretical level:** aims to expand our knowledge of human behaviour and mental problems transculturally to facilitate the development of more universally applicable and cross-culturally valid theories of psychopathology.

Recent advances in medical sociology, psychiatric anthropology and cross-cultural psychology make the domain of cultural psychiatry more broad and challenging (Kelly, 2010; Al-Issa, 1995). Following are the few issues of clinical importance from the trans-cultural point of view: Personality-culture interaction, psychosocial conflicts and problems related to rapid social change, attitudes and beliefs towards behavioural deviance in changing societies, multicultural communication styles, assessment of stress and cultural variation of coping and resilience, cultural change and psychic adaptation in the era of globalization and migration, technological advancement in communication and media, ecological changes and its impact on mental health, cultural principles in psychiatric diagnosis, clinical guidelines in cross-cultural mental health assessments, applications of therapeutic techniques to various ethnic groups, ethnopsychopharmacology and alternative (ethnobotany) or folk care, cultural determinants of public health policy, and the cultural implications of the new managed care approaches in the service delivery.

2.2 What is culture?

Culture is defined as a set of behavioural norms, meanings, and values or reference points utilized by members of a particular society to construct their unique view of the world, and ascertain their identity. It includes a number of variables such as language, traditions, values, rituals, customs, etiquette, taboos or laws, religious beliefs, moral standards and practices, gender and sexual orientation, and socio-economic status (GAP, 2002). All these issues are reflected in cultural products like common sayings, legends and folk lore, drama,

plays, art, philosophical thoughts and religious faith (Tseng & Strelzer, 2006). So, Culture is **learned** through active teaching, and passive acting, **shared** among its group members, **patterned** as having definite sets of beliefs and practices that guide different areas of individual and social life, **adaptive**, through change across variable environments and **symbolic** with many arbitrary signs that represent something special to the group. Culture is learned by the process of *enculturation* and is *transmitted* from generation to generation through family units and social environments. Culture operates at two levels: at the macroscopic level it represents the social and institutional pattern of a society at large and at the microscopic level it influences the individual thinking and behaviour, both consciously and unconsciously.

2.3 Various experiences with the cultural system

A **cultural system** may be defined as the interaction of different elements of culture with the individual or groups. It is a dynamic process and different from social system. Sometimes both systems together are referred as socio-cultural system.

Enculturation, an anthropological term, is the process by which a person learns the requirements of his/her own culture, and acquires values and behaviours that are appropriate or necessary in that culture (Grusec & Hastings, 2007). The process of enculturation is related to socialization. Enculturation is operative through child-rearing patterns, language development, and institutionalized education and through different abiding social systems. It is a learning process through introjections and absorption of value systems from parents, family members, neighbors, friends, school, social events, traditional literature and media.

Acculturation: is a process in which members of one cultural group adopting the cultural traits or social patterns of another group. Acculturation is an important process of cultural change in immigrated population (Berry, 1997) and influences their mental health (Bhui et al., 2005).

Acculturative Stress: It refers to the psychological, somatic, and social difficulties that may accompany acculturation processes. This was first described by Redfield et al. (1936) as, "psychic conflict" that may arise from conflicting cultural norms. Acculturative adaptation to a new culture is a complex and dynamic process whereby individuals continuously negotiate among accepting, adapting to, or denying the characteristics of a majority culture, as well as retaining, changing, or rejecting certain components of their own culture. This involves serious changes in multiple areas of functioning (e.g., values, behaviours, beliefs, attitudes, etiquette, moral judgement etc.), and for individuals, families, and groups engaged in this process, these adjustments are often experienced as stressful. The nature of familiarity and length of exposure to the new culture are important risk variables for the acculturative stress.

Assimilation: is the process whereby a minority group gradually adapts to the customs and values of the prevailing culture. It is a two-way process – firstly, an individual or a group of diverse ethnic and racial minority or immigrant individuals comes to adopt the beliefs, values, attitudes, and the behaviours of the majority or dominant culture and secondly, at the same time, they relinquishes the value system of their cultural tradition and becomes a member of the dominant society. Assimilation is a slow and a gradual process. The term has political and social implications also. *Assimilation Index* tells us how a migrant has assimilated (with the host culture) so that he/she is no longer seemed to be an immigrant. Vigdor (2008), from Manhattan Institute for Policy Research, uses Assimilation Index value

that can distinguish immigrants from U.S. natives, calculated on the basis of economic (employment, occupations, education, homeownership); cultural (ability to speak English, marriage to natives, number of children) and civic (naturalization, military service) information.

Cultural identity: is the identity of a group or culture or of an individual as far as one is influenced by one's belonging to a group or culture. The usual cultural identifiers are place, gender, history, nationality, ethnicity, language, religious faith, and aesthetics. Recognition of cultural identity is important for a culture-fare mental health care (Groen, 2009; Kent & Bhui, 2003).

Deculturation or Cultural Uprooting: Deculturation results when members of nondominant cultures become alienated (either by accident or by force) from the dominant culture and from their own minority society (Berry & Sam, 1980). As the deculturation is the loss of one's traditional culture without integration into a new culture so it is like a tree that has lost its roots- so called uprooting and there is a culture loss without replacement. The consequence of deculturation may results in increased stress and psychopathology (Cheetham et al., 1983) and cultural bereavement (Bhugra & Becker, 2005).

Cultural diffusion: is the spreading of ideas or products from one culture to another. This concept was first introduced by Kroeber (1940). There are three categories of cultural diffusion: *Direct diffusion* is when two cultures are very close to each other, resulting in intermarriage, trade, and even warfare. *Forced diffusion* occurs when one culture subjugates (conquers or enslaves) another culture and forces its own customs on the conquered people. Colonisation is the unique example. The term *Ethnocentrism* or *Cultural imperialism* is often applied to forced diffusion. *Indirect diffusion* is when cultural ideas are spread through a middleman or even another culture (e.g. spread of fast food MacDonald culture in Middle East). Recently, by technological advancements, media, TV, movies, culture may be transmitted to people far away without any direct contact.

Diaspora: is the movement, migration, or scattering of people away from an established or ancestral homeland. The term *Diaspora* carries a sense of displacement and a sense of hidden hope or desire to return to homeland. Safran (1991) described six criteria of Diasporas from migrant communities: the group maintains a myth or collective memory of their homeland; they regard their ancestral homeland as their true home, to which they will eventually return; being committed to the restoration or maintenance of that homeland; and they relate their identity with the culture of their homeland.

Cultural Paranoia: The concept was introduced by Grier & Cobbs (1968) in their book 'Black Rage', where they said that Black clients may not disclose personal information to White therapists for fear that they may be vulnerable to racial discrimination and this condition was regarded not a form of psychopathology but a healthy and adaptive response by African Americans towards the white Americans. This concept was further elaborated by Ridley (1984) but challenged by others (Homer & Ashby, 1986, Bronstein, 1986). Culture deeply influence our cognitive reference, perceptual experiences and belief system and thus have strong influence on persecutory ideas, shared delusions (Sen & Chowdhury, 2006) and even treatment seeking and hospitalization (Whaley, 2004).

Cultural Mistrust: It "involves the inclination among blacks to mistrust whites, with mistrust most evident in the areas of education and training, business and work, interpersonal and social relations, politics and law" (Terrell & Terrell, 1981). It may pose a great obstacle to health service delivery (Cort, 2004).

Culture shock: is the difficulty people have adjusting to a new culture that differs markedly from their own, usually occurs during visiting a new place or during a short-term sojourn (international students). Thorough phases of initial excitement and then negotiation and adjustment, people usually master the new environment. There are many symptoms and signs of culture shock, including general unease with new situations, irrational fears, difficulty with sleeping, feeling sick, anxiety and depression, preoccupation with health, and homesickness (Oberg, 1960). *Cultural confusion* results from a growing lack of consensus about what is proper or appropriate in a given circumstances. It is the initial phase of culture shock when people become confused, tired and disoriented in a new foreign environment.

Cultural Accommodation: It is the process by which individuals may take on values and beliefs of the host culture and accommodate them in the public sphere, while maintaining the parent culture in the private sphere.

Cultural Negotiation: It is an adjustment process that takes place at individual, interpersonal, and systemic levels. It occurs when individuals (e.g., adjusting immigrants in a new society or bicultural individuals having two cultural backgrounds) navigate diverse settings (e.g., school, home, work, community) and shift their identities and values depending on the norms of each environment. This allows individuals to fulfil differing expectations, obligations, and roles and to maintain relationships inside and outside their own cultural communities. Cultural negotiation helps to balance differing value systems, familial and community expectations, peer relationships, and identities.

Cultural Equivalence: Cultural equivalence is the term used in research methodology that is used to minimize the cultural bias and measurement error in the development and/or adaptation of assessment tools (Vandevijver & Tanzer, 2004). Five dimensions (conceptual, content, linguistic, technical, and normative equivalencies) are important and to be used to minimize measurement error in cross cultural applications.

2.4 Some useful concepts in cultural psychiatry

Race: Old concept of geographical race is now abandoned. Race is a socially and culturally constructed category not a biological validity. It is now believed that inequalities between racial groups are not consequences of biological inheritance but rather products of historical and contemporary social, economic, educational and political circumstances (AAA, 1999).

Ethnicity: It refers to social group of people whose members identify with each other from other groups by a common historical path, behaviour-norms and their own mark of group identities. The group members share a common language, religion, and a sense of a historical continuity of traditions and root culture. Ethnic variations of disease prevalence and ethnic health inequalities are important issues in mental health.

Minority: A racial, religious, political, national, or other group (relatively small) thought to be different from the larger group in a society. The status of a minority may be acquired by: (a) Native people after they have been invaded, taken over or destroyed by militarily, technologically or economically superior outsiders- the whole range of colonization is the example, e.g., .Native Americans in North America, native aborigines in Australia and Canada. (b) Racial background and historical path of migration to a host country - African-Americans in USA/ East Indians in Europe/ Tibetans in India. (c) Ethnic origin- like Hutterite in USA or Dalits in India and (d) Religious affiliation- Muslims in India/Hindus in Bangladesh.

Society: Composed of a large social grouping that shares the same geographical or virtual territory, subject to the same political authority and dominant cultural expectations and organized by an administrative structure and regulated by certain rules or systems. Several cultures or subcultures may exist within a single society.

Subculture: A cultural group within a larger culture, often having beliefs or interests at variance with those of the larger culture. The smaller subcultures usually have the same racial background as the majority group, but they choose to have distinctly different sets of beliefs, value systems and life style. E.g. Amish in USA. In mental health the term often used with different connotations like drug subculture, criminal subculture, urban subculture or youth subculture etc.

Social Class: refers to the social stratification in a society. Sociologists use *Socio-Economic-Status (SES)* that includes variables like education, occupation and income. In mental health, social class is considered primarily the product of the perceptions and beliefs held by people in different subgroups in a society like upper class, middle working class and lower class, which are associated with certain lifestyles, values and ethics. An extreme example is the caste system in India. These classes seldom changes radically but SES is changeable across the social ladder.

Primary Cultural Characteristics: things that a person cannot easily change, but if they do, a stigma may occur for themselves, their families or society. It includes nationality, race, colour, gender, age and religious affiliation.

Secondary Cultural Characteristics: includes educational status, SES, occupation, political beliefs, urban vs. rural residence, enclave identity, sexual orientation, gender issues, marital status, parental status, length of time away from the country of origin, migration status.

Worldview: the way individuals or groups look at the universe to form basic assumptions and values about their lives and world around them. It is the fundamental cognitive orientation of an individual or a society involving philosophy, cosmology, relationship with nature, existential meaning, moral and ethical reasoning, social relationships, magico-religious beliefs, values, emotions and ethics (Palmer, 1996).

Cultural Relativism: The concept of cultural relativism was first postulated by the German-American anthropologist Franz Boas (1858- 1942) in 1887 and later the term was coined by Alain LeRoy Locke (1885-1954), an American philosopher in 1924. Cultural relativism maintains the view that all cultures are equal in value and therefore should not be judged on the basis of another cultural perspective. It supports the belief that mental health should be understood through the context of normative behaviour within a specific culture. Proponents argue that issues like abortion, euthanasia, female circumcision and physical punishment in child rearing should be accepted as cultural practice without judgement from the outside world. Opponents argue that cultural relativism may undermine condemnation of human right violations, and family violence cannot be justified or excused on a cultural basis. There is some ongoing debate between universalistic and relativistic opinions about how cultures influence the manifestation of mental illness. According to the universalistic view the core psychiatric disorders are universal and what may vary across cultures are the symptomatic manifestation of the disorder or the threshold of labelling pathological versus normal behaviour.

Cultural diversity: encompasses the cultural differences that exist between people, such as language, dress and traditions, and the way societies organize themselves, their conception of morality and religion, and the way they interact with the environment. The Universal

Declaration on Cultural Diversity was adopted by UNESCO (2001) and declared cultural diversity as “common heritage of humanity”, where the main focuses are: (a) the diversity of people’s backgrounds and circumstances is appreciated and valued, (b) similar life opportunities are available to all, and (c) strong and positive relationships exist and continue to be developed in the workplace, in schools and in the wider community and society. Careful and ethical consideration of cultural diversity is a key issue in mental health because it aims to integrate cultural awareness, and cultural sensitivity into clinical practice and training, which have impacts on the quality of mental health service provision to individuals from minority ethnic communities (Bhui & Bhugra, 2002a). In this era of globalization and interconnected world we are living in a multicultural society and thus the core principle of mental health today is the unity within diversity (Brody, 2001).

2.5 Some key issues in cultural psychiatry

Following are the few important socio-anthropological issues, that mental health professionals should have in his/her mind during the cultural history taking in cross-cultural context.

Cultural variations of Family Systems: Family system functions as a unit, and every family member plays a unique role in the system. So change in any one member of the system will influence, by a ripple effect, the whole family system. Issues like kinship system, family structure, primary axis, interpersonal-dynamics, one-parent family, and family violence are important psychologically. Family organization (extended/nuclear) and relational roles (patriarchal or matriarchal systems) vary across cultural or subcultural groups.

Child development and enculturation process: upbringing process, cultural rituals and ethics in child rearing, gender-based customs, schooling, childhood trauma or abuse- all have significant impact on personality development.

Marriage system: gender role, its cultural meaning and responsibilities, socio-cultural implication of bride wealth or dowry system.

Culture and Personality development: socio-cultural environment, acquisition of values, beliefs and expectations, development of emotionality in the socialization process.

Social Customs: habitual ways of behaving carried out by tradition and enforced by social sanctions- customs relating to exposure of body parts, food choices, sexuality, substance abuse/ drinking, social interaction and restrictions etc.

Rituals: is a set of actions, performed mainly for their symbolic value, e.g., traditional practice of certain sets of or prescribed ceremonies like rituals with birth, puberty, wedding and death. In some cultures there are varieties of health rituals exists.

Etiquette: refers to the code of expected social behavior according to conventional norm within a society or a group, same as ‘manners’ in social interactions. To know the etiquette of a target culture is beneficial in cross-cultural communication.

Taboos: a social prohibition or restriction on certain things or behaviour, breaking of which is socially unacceptable because of the belief that it might result in ill effect. In every culture there are some superstitious beliefs and set rules of avoidance of some behaviours or objects.

Culture and Gender: Gender refers to the ways in which cultures differentiate and define roles based on biological sex and reproductive functions. Men and women do have some fundamentally different experiences of their bodies, of their social worlds and of their life course. There are also important gender differences in styles of emotional expression, symptom experience, social expectations and help seeking. Gender equality and freedom differs from culture to culture. In mental health, gender difference influence rates of

common mental disorders, there are gender specific risk factors and gender bias occurs in the treatment of mental illness (WHO, 2011; Emslie et al., 2002).

Attitudes and views about ageing: in some culture aged persons are more respected and listen to, have role in decision making, aged persons are more vulnerable to neglect and exploitation, have less access to health care.

Beliefs about health-illness-healing: beliefs in bad deed or *karma*/ancestral or God's punishment/ evil eye or sorcery / witchcraft/ possession/ supernatural force may influence illness experience and help seeking. In some cultures there may be strong resistance to blood transfusion or blood tests. Culture strongly influences illness beliefs and thus enhances 'psychic infectivity' in some psychiatric epidemics (Chowdhury, 1992a). Ethnomedicine or the study of cross-cultural health system (Banerjee & Jalota, 1988) is one of the central topics in cultural psychiatry.

Views about Birth, Death and Mourning: influence emotional reactions, grief and bereavement. Numerous cultural rituals involve the phenomenon of death. Some of these rituals may preclude the conduct of an autopsy.

Value system: Values are powerful drivers of how we think and behave. Values are a significant element of culture, where they form a part of the shared rule- set of a group. If someone transgresses other's value it may lead to betrayal responses (distress, loss of trust and seeking justice). Health professionals should be cautious of the values in practice. There are many categories of value like personal, social, political, economic and religious.

Idioms of Distress: Culture heavily influences how people understand and respond to distressing events. Distress is not expressed in the same way in all cultures or communities. In some culture distress is expressed by 'somatisation': people complain of physical symptoms which are mainly caused by emotional or mental worry, anxiety, or stress. The term 'idioms of distress' has been used to describe specific illnesses that occur in some societies and are recognized only by members of those societies as expressions of distress. A good example is the term 'nerve' which is used in many societies to designate both physical pain and emotional discomfort and is clinically presented with bodily pain, fatigue, insomnia or feelings of sadness, tension, and weepiness (Scheper-Hughes, 1992).

Disease and Illness: Disease, a biological construct, represents all the manifestations of ill health in response to some pathological process and is translated into nosological descriptions of signs/symptoms under medical framework. Illness, a socio-cultural construct, having a symbolic nature, and primarily represented by the subjective, emotional, behavioural, interpretative and communicative responses of the affected individual (Eisenberg, 1977). Cultural explanation and ethnomedical worldview influence the perception of illness and health, healing (Boyd, 2000) and sick role and illness behaviour (Chowdhury & Dobson, 2002).

Explanatory Model of Illness (EMI): Patient's illness beliefs influence their symptom formation and degree of disability (Fig.1). Klienman (1992) suggested that by exploring the *explanatory model* of illness we can better understand our patients and families: "Explanatory Models are the notions about an Episode of sickness and its treatment that is employed by all those engaged in the clinical process." He provided a very simple 'What, Why, How and Who' questions to elicit patient's explanation about illness (Box 1). Weiss (1997) further developed this into different clinical sets of Explanatory Model Interview Catalogue for different cultural and clinical groups across different countries. Explanatory model is a very useful clinical tool not only in mental health assessment (Bhui & Bhugra, 2002b; McCabe & Priebe, 2004) but also in other areas of medicine (Ross et al., 2002; Hallenbeck, 2003).

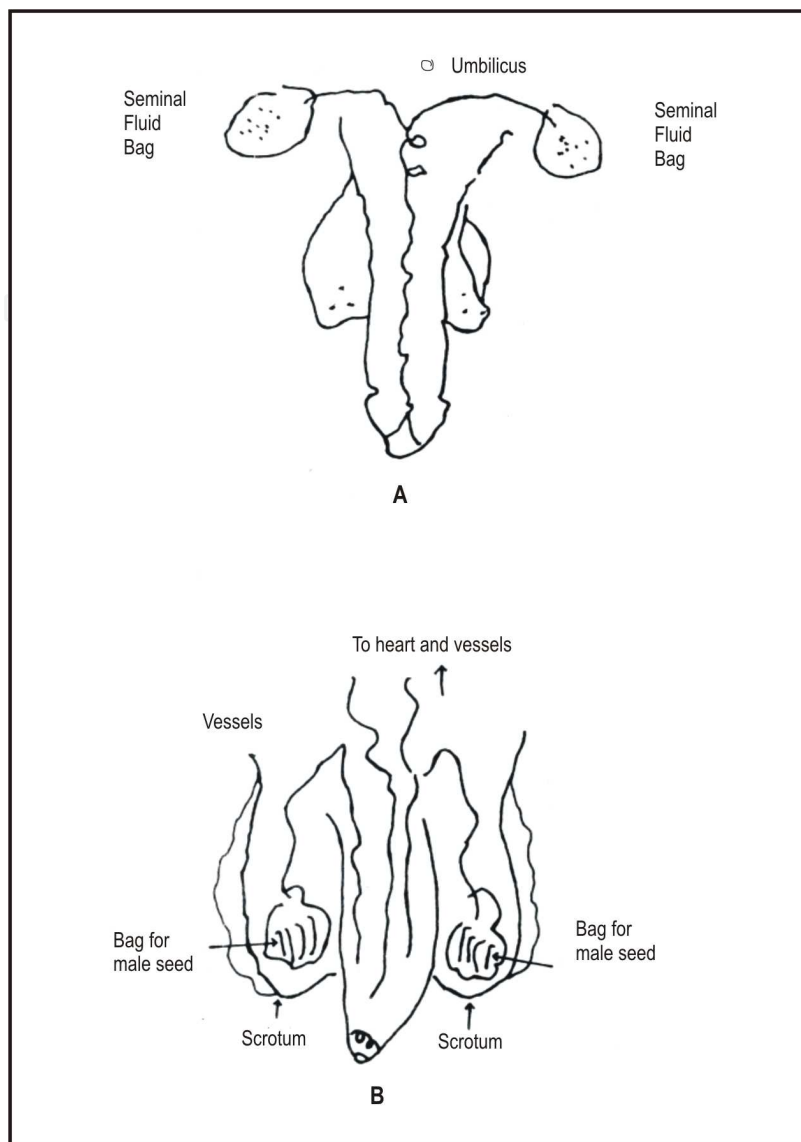


Fig. 1. **Body-heat explanatory model of Indian Koro patients** (Chowdhury, 2008). Increased body heat was implicated for the sudden 'pulling-in' of the penis. A. Drawing by a 22 year boy with Dhat syndrome - showing the *penile pull* was active from both the seminal fluid bag in the abdomen. B. Drawing by a 34 year male school teacher with Scrotal Filariasis - showing that the *pulling force* was operative from the heart

2.6 Culture and psychopathology

How does Culture relate to Psychopathology? Tseng (2003) provides a very practical clinical construct about how culture influence psychopathology. He provided seven types of effects as follows:

2.6.1 Pathogenic Effects: refers to situations where culture is a direct causative factor in forming or generating psychopathology, e.g. *stress* can be created by culturally formed anxiety, culturally demanded performance or culturally prescribed roles and duties. So culture is considered to be a causative factor, because culture-specific beliefs and ideas contribute directly to the formation of particular stress inducing certain type of psychopathology. Culture-Bound Syndromes are the example.

Culture Bound Syndromes (CBS)

Culture-bound or culture-specific syndromes cover an extensive range of disorders occurring in particular cultural communities or ethnic groups. The behavioural manifestations or subjective experiences particular to these disorders may or may not correspond to diagnostic categories in DSM-IV-TR or ICD-10. They are usually considered to be illnesses and generally have local names. They also include culturally accepted idioms or explanatory mechanisms of illness that differ from Western idioms. There is some conceptual confusion with the term 'Culture-bound'. In the widest sense everything is culture-bound. Here the word 'bound' implicates that the symptoms describe is confined to one specific culture, but in reality they may be found in multiple cultures (may be by different name). So Levine and Gaw (1995) suggested more precise term for CBS as "folk diagnostic categories". Some researchers, in a wider sense, debated the Eurocentric role of culture-boundness even with cultural psychiatry in the global context (Jadav, 2004).

Awareness of culture-bound syndromes is important to help psychiatrists and physicians to make culturally appropriate diagnoses (Chowdhury et al., 2003). The concept is also interesting to medical and psychiatric anthropologists because the culture-bound syndromes provide examples of how culturally salient symptoms can be elaborated into illness experiences. CBS was included in the fourth version of Diagnostic and Statistical Manual (APA, 1994) and provided symptomatic descriptions of 25 culture-bound syndromes in the Glossary of Culture-Bound Syndromes in appendix I (Table 1). Simons and Hughes (1985) provided a comprehensive list and description of CBS as reported globally. Though CBS is mainly implicated to non-Western cultures but in recent years, there is increased recognition by cultural psychiatrists of syndromes in western culture (Littlewood, 2002) that are heavily culture-related like anorexia nervosa (Swartz, 1985); obesity (Ritenbaugh, 1982), drug-induced dissociative states, multiple personality or personality disorders (Alarcon et al., 1998) and premenstrual tension syndrome (Johnson, 1987).

Guarnaccia and Rogler (1999) provided a set of four key questions for clinical analysis of CBS in the context of culture and psychopathology. These are:

1. *Nature of the phenomenon?* The character of CBS in the context of a given culture and what are the defining features of the phenomenon?
2. *Location in the social context:* who are affected? What is the social structural location and who are at risk or any situational trigger?
3. *Relationship to Psychiatric Disorder:* Empirical relation of CBS with designated psychiatric disorder? Any comorbid psychiatric disorder? The CBSs often coexist with other psychiatric disorder, as many psychiatric disorders do with each other. Delineation of comorbidity factor will in help in clinical decision making.

Example: Epidemiological study in Puerto Rico (Guarnaccia et al., 1993) showed high rate of psychiatric disorder among those reporting ataque de nervios (63% vs. 28% of the sample) - 3.5 times more likely to meet criteria for an anxiety disorder and 2.75 times more likely to meet the criteria for an affective disorder than those who had not reported an attack de nervios.

4. *Different comorbidities:* Difference in the symptomatic, emotional and contextual aspects of cultural syndromes, may show different subtypes of the designated psychiatric disorder.

Example: Koro or genital retraction syndrome has offered a unique opportunity to study comorbidity in CBS, as over the years Koro has been reported from diverse culture and ethnicity (Chowdhury, 1996; 1998). For example: Koro with high sex guilt and

depressive reaction (Chowdhury, 1992b, Chowdhury & Rajbhandari, 1995) or with heightened sexual anxiety and anxiety disorder (Chowdhury, 1990) or with hypersuggestability and hysterical reaction (Chowdhury, 1994a) and even sometimes with medical comorbidities (Chowdhury, 1989; Puranik & Dunn, 1995).

Name (Geographical/cultural location)	Presentation
Amok (Malaysia, Indonesia, Philippines, Brunei, Singapore)	Dissociative episode- violent and homicidal behaviour, usually preceded by brooding over real or imagined insults.
Ataque de nervios (Nervous attack) (Latin-America)	Brief, intense release of emotion believed to be caused by family conflict or anger.
Bilis (Rage)	Outburst of anger.
Boufée délirante (West Africa and Haiti)	Outburst of agitated, aggressive behaviour, marked confusion, psychomotor excitement, often with visual and auditory hallucinations or paranoid ideation.
Brain fag or brain fog (West Africa)	Usually among high school or university students. Symptoms: difficulties in concentrating, remembering, and thinking.
Dhat syndrome (Indian subcontinent)	Sexual/ general weakness due to loss of semen through urine or faeces.
Falling out/blacking out (Southern USA, Caribbean)	Episodes of sudden collapse and fainting, often with hysterical blindness.
Ghost sickness American Indian (Novajo)	A syndrome, associated with dead or dying, attributed to ghosts (<i>chindi</i>) or witchcraft. Symptoms are general weakness, loss of appetite, feeling of suffocation, recurring nightmares and a pervasive feeling of terror.
Hwa-byung (Anger sickness) (Korea)	Epigastric pain, usually female, shortness of breath, flushing, indigestion, palpitations, vomiting, cold hands, dysphoria from an imagined abdominal mass, thought to be caused by suppressed or unresolved anger, disappointment or grudges.
Koro (China, Malaysia, India, SEA)	Acute fear- genitalia will retract into the body (also breast into the chest in female), causing death.
Latah (Malaysia, Indonesia)	Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behaviour.
Locura (Latinos in USA/ Latin America)	Chronic psychosis with incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, and possible violence- attributed to an inherited vulnerability or life adversities.
Mal-de-ojo (Evil eye) (Mediterranean, Hispanic)	A common idiom of disease, attributed to any misfortune, and social disruption.
Nervios (Latinos in USA/ Latin	Refers to a general state of vulnerability to stressful life experiences and difficult life circumstances. A wide range of symptoms: emotional distress, somatic disturbance,

Name (Geographical/cultural location)	Presentation
America)	and inability to function. Common symptoms: headaches, brain aches, irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and mareos (dizziness with occasional vertigo-like exacerbation).
Pibloktoq (Arctic hysteria) (Arctic circle, Inuhuit Eskimos)	Symptoms: hysterical (screaming, uncontrolled wild behaviour), depression, coprophagia, echolalia, insensitivity to extreme cold. Common in winter and among women.
Gi-gong (Psychotic reaction) (China)	An acute, time-limited episode characterized by dissociative, paranoid, or other psychotic or nonpsychotic symptoms that occur after participating in the Chinese folk health-enhancing practice of <i>qi-gong</i> .
Rootwork (African American, Caribbean, White population in Southern USA)	Cultural interpretations that explain illness as the result of hexing, witchcraft, voodoo, or the influence of an evil person.
Sangue dormido (Portuguese in Cape Verde)	Literally “sleeping blood” with symptoms of pain, numbness, tremor, paralysis, convulsions, stroke, blindness, heart attack, infection, and miscarriage.
Shenjang shuairuo (Neurasthenia) (India, China)	Mental and physical fatigue, poor concentration and memory, headache, dizziness, changes in sleep, appetite, sexual function.
Shen kui (China)	Anxiety, panic and sexual complaints with no physical findings, attributed to loss of semen or ‘vital essence’.
Shin-byung (Korea)	A syndrome characterized by anxiety and somatic complaints like general weakness, dizziness, fear, loss of appetite, insomnia, and gastrointestinal problems, followed by dissociation and possession by ancestral spirits.
Spell (African American, White population in Southern USA)	A trance state in which individuals “communicate” with deceased relatives or with spirits.
Susto (Latinos in USA, Mexico, Central America, South America)	Attributed to an illness precipitated after a frightening event that causes the soul to leave the body, leading to symptoms of unhappiness and sickness.
Taijin Kyofusho (Social phobia) (Japan)	Guilt about embarrassing others- an intense fear that one's body, body parts, or bodily functions are displeasing, embarrassing, or offensive to other people.
Zar (Ethiopia, Somalia, Egypt, Sudan, Iran, and Middle East)	Experience of spirit possession- presented with dissociative episodes with laughing, shouting, hitting the head against a wall, singing, or weeping.

Table 1. DSM IV (2000) list of some common CBSs (Trujillo, 2008; Hall, 2008)

2.6.2 Pathoselective Effects: cultural choice to stress reaction that shapes the nature of psychopathology, e.g., Running amok in Malaysia, familial suicide in some cultures.

2.6.3 Pathoplastic Effects: the ways in which culture contributes to modeling or plastering of the manifestation of psychopathology- this acts in two ways: *Shaping the content of the symptoms:* content of delusions, hallucinations, obsessions or phobias is subject to psychosocial context in which the pathology is reported. *Modeling the clinical picture as a whole* - Taijin-kuofu-sho in Japan and Brain fog syndrome in Nigeria. Culture plays a pathoplastic role in some psychiatric epidemics also (Chowdhury et al., 1993).

2.6.4 Pathoelaborating Effects: Certain behaviours (either normal or pathological) may become exaggerated to the extreme by *cultural reinforcement*: Latah in Malaysia is being utilized by people for social amusement; *hara-kiri* – formal way of suicide by a soldier in Japan to avoid capture or humiliation by enemy is an honourable way of ending one's life. Verbal insult for non-payment of loan may be a justified reason for attempting self-harm in some Asian communities. Cultural notion of body-image/ shape, diet and body weight regulation to an extreme degree are good example of this category in recent health-conscious and commercially driven urban culture.

2.6.5 Pathofacilitative Effects: Many psychiatric disorders are intimately tied to psychological and sociocultural variables in their development, e.g., suicidal behaviour (Chowdhury, 2002), alcoholism (Chowdhury et al., 2006), and substance abuse, e.g., initial social tolerance towards involvement of unemployed youths in drug trafficking activities resulted in high incidence of heroin dependence and HIV infection in Monipore, India (Chowdhury, 1994b).

2.6.6 Pathodiscriminating Effects: Sociocultural labeling of behaviour as normal or abnormal- several mental conditions or behaviours, e.g., personality disorder, sexual deviation and substance abuse are accepted or rejected as per the social discrimination according to cultural factors.

2.6.7 Pathoreactive Effects: Culture influences how people label a disorder and how they emotionally react to it. Prognosis of schizophrenia is better in less developed, rural, farming societies than industrialized nations. The social environment, attitudes of family and community determine how well the person will rehabilitate into social and family life, thus affecting the prognosis. Excessive and often overrepresentation of risk from mental patients in the media and the public reaction thereof (stigmatizing mental patients) in the Western world is a good example of this category (BBC, 1999; Edney, 2004).

3. Cultural competency in health care

All our clinical interactions take place in the context of culture. Culture always matters in health care, if the culture is ignored or overlooked, individuals and families are at risk of not getting the required support, or worse yet, receiving service that is more harmful than helpful.

3.1 Culture gives context and meaning of symptom or distress

Culture is a filter through which people process their understanding, experiences and impact of life events. Culture influences people's values, actions, and expectations of

themselves and of others and thus influence their behaviour. Culture provides the world-view about health, healing, and wellness beliefs- both to clients and professionals. Culture influences the help-seeking behaviours of patients, their attitudes and expectation toward health care providers and thus influence treatment acceptance and compliance (Chowdhury, 1991).

Everyone has a culture. It is the core issue in identity, behavior and world views. Everyone lives in multiple cultural orbits: ethnic, religious, class, gender, race, language, and social network (Olsen et al., 2006). Cultures are not static. It changes and evolves over time as individuals change over time. It involves continuous change in response to varied circumstances, challenges and opportunities. Culture is not determinative. Different people take on and respond to the same cultural expectations in different ways. Assumptions therefore cannot be made about individuals based on a specific aspect of their cultural experience and identity.

3.2 What does it mean to be culturally competent?

Cultural competency (CC) is "a set of academic and personal skills that allow us to increase our understanding and appreciation of cultural differences between groups" (Cross et al., 1989). Becoming culturally competent is a developmental process. It includes the ability to understand the language, culture, and behaviors of other individuals and groups, and to make appropriate clinical recommendations. The goal of CC is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, gender, ethnicity, culture, or language proficiency (Betancourt et al., 2005).

3.3 Why is cultural competency important for health professionals?

CC is the ability to interact successfully with patients from various ethnic and/or cultural groups. The increasing cultural diversity of recent era demands the delivery of culturally competent services. Every health professions should be aware of these three issues: (a) **Lack of awareness:** about cultural differences can make it difficult for both providers and patients to achieve the best, most appropriate care in a culture-conducive way. (b) **Diversity:** Despite all our similarities, fundamental differences among people arise from nationality, ethnicity, and culture, as well as from family background, individual experiences and current cultural disposition. The differences and similarities among diversity should be recognized, celebrated, and respected. Understanding of cultural diversity improves mental health service within a framework of legitimate practice (James & Prilleltensky, 2002). (c) **Expectations:** Cultural, ethnic, linguistic, and economic differences influence how individuals or groups access and use health, education, and social services (Lauu, 2000). These differences affect health beliefs, practices, and behaviour on the part of both patient and provider, and also influence the expectations that patient and provider have of each other.

Often in the therapeutic setting there is lack of awareness of these differences, mentioned above, and their impacts, which may be devastating and may lead to:

1. **Miscommunication:** Patient-provider relationships are affected when understanding of each other's expectations is missing. The provider may not understand why the patient does not follow instructions: e.g., why the patient takes a smaller dose of sleeping medicine than prescribed (because of a belief that Western medicine is "too strong and may damage heart"); or why the family, rather than the patient, makes important

- decisions about the patient's health care (because in the patient's culture, major decisions are made by the family as a group).
2. **Rejection:** Likewise, the patient may reject the provider (and the entire system) even before any one-on-one interaction occurs because of non-verbal cues that do not fit expectations. For example, "The doctor is not wearing a white coat - maybe he's not really a doctor; or, "The doctor smiles too much. Doesn't she take me seriously?"
 3. **Cultural Distance:** A gap between the culture of two different groups, such as that between the culture of institutions/clinician and the service user or their families. Mental health service delivery faces this challenge especially to reach the ethnic minority clients (Littlewood & Lipsedge, 1988; Saha, 2006).

3.4 Rationale for cultural competency

Many studies and official reports showed disparity in health care due to *cultural incompetence*. The Report of Surgeon General on Mental Health (1999), USA, highlighted several disparities between racial and ethnic minorities and whites where Minorities (a) have less availability of, and access to, mental health services, (b) are less likely to receive needed mental health services, (c) often receive a lower quality of mental health care and (d) are underrepresented in mental health research. Some studies have clearly delineated that patient's race and gender affect physician's medical decision making (Cooper-Patrick et al., 1999; Weisse et al., 2001).

Meyer (1996) describes four major reasons why we need CC in healthcare. These are: (1) Difference in clinical presentation among different ethnic and racial groups, (2) Language and communication difficulties, (3) Ethical issues and decision making- western medicine versus traditional/folk medicine or practice and (4) Trust/respect - cultural variation of levels of trust towards authority. So CC virtually offers a wide range of service development in a culture-fair way (Anderson et al, 2003) and is providing definite advantage in service delivery in a multicultural society as follows:

1. CC = Quality of Care and service outcome,
2. CC = Disparity Reduction (Eliminating disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds),
3. CC = Risk Management (more understanding of the client's behaviour to mitigate risk),
4. CC = Linguistic Competence - One necessary aspect of cultural competence is linguistic competence,
5. CC = Responding to demographic changes in the society,
6. CC = Help to reduce the likelihood of liability or malpractice claims,
7. CC = A Fundamental Social (often legal) Responsibility- reflects the basic value-base of the public mental health approach, which should be responsive to individual needs and preferences,
8. CC=Meets the obligation to respect UNO's Cultural Diversity and Racial Discrimination protocol.

3.5 Types of CC: There are two types- Individual and Organizational

3.5.1 Component of Organizational CC: The organization should have (1) clearly articulated vision regarding the importance of diversity and inclusion to the business of the organization, (2) should do Climate survey to assess the degree to which individuals and members of the groups perceive they are valued, rewarded and have opportunities for growth and should

provide (3) ongoing education, mentoring and evaluation throughout the organization for employees and managers to understand the expectations and skills necessary for developing a culturally competent organization. A culturally competent organization ensures that a commitment to CC can be seen throughout all levels of the hierarchy.

3.5.2 Components of Individual CC

CC exists on a continuum from incompetence to proficiency.

At individual level CC comprises five components (Papadopoulos et al., 2004):

1. **Cultural desire:** genuine motivation to engage in the process of cultural competence and commitment to self-evaluation and criticism to develop cross-cultural knowledge.
2. **Cultural Awareness** of one's own cultural worldview (values, beliefs and practice) to reduce the risk of cultural bias and conflict in therapeutic assessment and decision making.
3. **Attitude** towards cultural differences, i.e., appreciating and accepting differences. Two ways of enabling attitudes are by: *Sensitivity training*: Reflect on culture, racism, sexism, etc. / *Case studies and Awareness training*: Population level statistics or ethnic disease prevalence data can alert the presence of minority groups and their needs in the area served.
4. **Knowledge of different cultural practices and worldviews.** It is the most important part for the development of cultural competencies. The key focus here is the acquiring of *Inter-cultural knowledge*, i.e., deliberately seeking out various world views and explanatory models of disease. Knowledge promotes understanding between cultures, failure of which may lead to intentional or unintentional discrimination (Purnell, 2005). Following are the few areas of knowledge which are essential for the mental health professionals (Saldana, 2001): (A) *Knowledge about specific facts related to culture of the client*: (a) Clients' culture: history, traditions, values, family systems, artistic expressions; (b) roles of language, speech patterns, communication styles, help-seeking behaviors, and (c) impact of racism and poverty on behaviour, attitudes, values, and disabilities. (B) *Knowledge about the culture of service and institution*: (a) the impact of the social service policies on clients of colour; (b) available resources (i.e., agencies, persons, informal helping networks, research) available for ethnic minority clients and communities; (c) how power relationships within communities or institutions impact different cultural groups, and (d) how professional values may either conflict with or accommodate the needs of clients from different cultural background.
5. **Cross-cultural Skill:** Focused on the ability and desire to combine awareness and knowledge to interpret and incorporate culture-specific understandings into primary, secondary and tertiary healthcare settings. Four ways to achieve it are:
 - a. *Cultural skill development*: Learning how to culturally assess a patient, explaining an issue from another's perspective; reducing resistance and defensiveness; and acknowledging interactive mistakes that may hinder the desire to communicate.
 - b. *Cultural encounters*: Meeting and working with people of a different culture will help dispel stereotypes and may contradict academic knowledge. Culturally competent skill should help to be humble enough to fight stereotypes and remain open to the individuality of each patient.
 - c. *Cultural empowerment*: Professional ability to openly discuss racial and ethnic differences and issues and to respond appropriately to culturally based cues, ability

to utilize the concepts of empowerment on behalf of culturally different clients and communities and proactive to recognize and combat racism, racial stereotypes, and myths among individuals and institutions.

- d. *Cross-Cultural communication*: One of the most important learning processes in the development of cultural competency.

3.6 Cross-cultural communication

Cross-cultural or Inter-cultural communication is the interaction with persons of different cultural, ethnic, racial, gender, religious, age and class backgrounds. It is a process of exchanging, negotiating, and mediating one's cultural differences through language, non-verbal gestures, and space relationships. Cultural background, health beliefs and treatment expectations affect health care encounters with every patient (Kai, 2005). Different cultures have different 'set rules' that influence the behaviour, pattern of speech, value judgement, concept of time and interpersonal space and emotional attitudes towards distress and dysfunctions. Intercultural communication involves understanding others and making you understood by others. Culturally competent communication reduces racial and ethnic disparity in health care (Taylor & Lurie, 2004).

Communication is an important component of patient care (Skelton et al., 2001). With globalization and increased influx of multicultural population groups, cross-cultural communication is becoming an integral part of medical education and care (Stumpf & Bass, 1992). It is currently getting increased attention from medical schools and accreditation organizations (Loudon et al, 1999). There is also increased interest in researching patient-doctor communication and recognizing the need to teach and measure this specific clinical skill (Teutsch, 2003).

Cross-cultural communication is an ongoing learning process and involves many barriers, blocks and new initiatives and skill (Mull, 1993). Health professionals should be aware of three limitations that may interfere with effective cross-cultural understanding (Ting-Toomey, 1999): *Cognitive constraints* - These are the existing frames of reference or world views that provide a backdrop where all new information is compared, contextualized and inserted. *Behaviour constraints* - Each culture has its own set rules about proper behavior which affect verbal and nonverbal communication. The *Emotional constraints* are the ways of emotional regulation which varies from culture to culture. So for every health professionals, these three personal agenda need constant updating, viz., cognitive competence, affective competence and role competence.

3.6.1 Cultural differences in communication

Recognition of cultural differences in communication is important in therapeutic negotiations. Following are the few examples (DuPraw & Axner, 1997):

1. *Different Communication Styles*: The way people communicate varies widely between, and even within, cultures. Three aspects of communication style are important: language use, non-verbal communication and degree of assertiveness in communication (reflect positivity and confidence). Language use differs from culture to culture. Across cultures, some words and phrases are used in different ways. Even in English, the word 'Yes' has many connotation depending on the way it is said. Nonverbal communication, or body language, is a vital form of communication. When we interact with others, we continuously give and receive countless wordless signals (Argyle, 1988). The *Static* non-verbal communications include: Distance, Orientation

- (face to face/ side-by-side) Posture (of formality/relaxed/tensed) and Physical Contact (shaking hands/ touching/ holding/ embracing/ pushing). The *Dynamic* nonverbal communications are: Facial Expressions (smile, frown, raised eyebrow/ yawn/ sneer), Gesture (hand movement), Eye Contact, Kinesis (movements – forward/backward, vertical or side-to-side), Touch (Tactile Communication), Personal Space (Proxemics): the space you place between yourself and others, Environment (arrange objects into your environment), Silence (its meaning underneath) and Time. All these issues are highly culture-dependent.
2. *Different Approaches to Completing/Handling Tasks*: The success of any medical assessment and treatment negotiation virtually depends on the willingness of the client to complete the task. There are different ways that people handle tasks in terms of time frame, following of instructions, value judgement of the therapeutic decision offered and feedback as and when necessary. This may reflect in treatment negotiation, adherence or compliance to the management plan in a psychiatric clinical setting. Cultural framework in relation to time management, sense of reciprocal responsibility and trust influence how one takes the task at hand.
 3. *Different Decision Making Styles*: The roles individuals play in decision-making vary widely from culture to culture. This is an important issue in accepting the treatment decision. In some culture a strong value is placed on holding decision-making responsibilities oneself and in some cultures decision needs affirmation from the family members (Asian Culture) or from the clan head before starting treatment (Some African culture).
 4. *Different Attitude toward Disclosure*: Disclosure is a very sensitive as well as crucial issue in medical assessment. Frank reporting of sensitive personal issues varies from culture to culture. Potential problem may arise in areas like history taking on Drug/HIV or sexual history or history of abuse or domestic violence.

3.6.2 Factors that impede cross-cultural communications

Lack of Understanding: One of the major barriers to effective cross-cultural communication is the lack of understanding of client's culture.

Personal Values: Health professional's personal values may constitute a significant barrier, which may be due to class-bound values or culture-bound values (Sue & Sue, 1977).

Judgmental Attitudes: Tendency to evaluate other's values, beliefs and behaviours in a negative way.

Prejudice: Tendency of 'pre-judging' someone's characteristics simply because they have been categorised as belonging to a particular group. It is usually associated with negative attitudes to that group and often has ethnic or racial overtones.

Discrimination: Differential treatment of an individual due to minority status; actual and perceived; e.g., "here we have no facility to serve people like that."

Generalization: reducing numerous characteristics of an individual or group to a general form that is oversimplification, e.g., "All Caribbeans are highly superstitious".

Stereotyping: an oversimplified conception, opinion or belief about some aspect of an individual or a group. To categorize and make assumptions about others based on identified characteristics (such as gender, race, ethnicity, age, religion, nationality, or socioeconomic status) is a serious mistake. e.g., "she's like that because she's Indian – all Indians are shy and nonverbal."

Ethnocentrism: The tendency to evaluate other groups according to the values and standards of one's own ethnic group, especially with the conviction that one's own ethnic group is

superior to the other groups (as if “my way is the best in the world”). Ethnocentrism leads to make false assumption about cultural differences and helps to make premature judgement. It is an obstacle to intercultural communication (Dong et al., 2008). Clinical practice in Western psychiatry is very often criticised as an ethnocentric discipline (Ata & Morrison, 2005; Fernando, 1991).

Cultural imperialism: is the practice of extending the policies and practices of one group (usually the dominant one) to other or minority groups.

Cultural Imposition: is the intrusive application of the majority group’s cultural view upon individuals and families - belief that everyone should conform to the majority; e.g., “we know the right thing for you, if you don't like it you may go elsewhere.”

Cultural Blindness: Differences are ignored and one proceeds as though differences did not exist; e.g., “there's no need to worry about a person's culture – you do your job and that is enough”.

Racism: Race has social meaning, assigns status, limits or increase opportunities and influence interaction between patient and clinicians. Racism has been described as prejudice combined with power (Abrums, 2004). United Nations (1965) ‘International Convention on the Elimination of All Forms of Racial Discrimination’ defines racism as: “Any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on equal footing, of human rights & fundamental freedoms in the political, economic, social, cultural or any other fields of public life”. Racism may be overt or covert.

“Institutionalised racism consists of the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people” (Lancet, 1999). Stokely Carmichael, a Trinidadian-American black activist, coined this term in 1960. Racism in health care is a very sensitive and challenging issue in UK, USA and other European countries (Bhopal, 2007), especially in work place, medical (Dennis, 2001; Mistry & Latoo, 2009), and psychiatric service delivery (McKenzie & Bhui, 2007). *Racial fatigue* is the state of potential emotional and psychological sequel of feeling isolated in a work or health environment because of racial discrimination, especially when the issues were consistently ignored and not discussed (*racial silence*) (Nunez-Smith et al., 2007).

Stigma: Stigma is a severe form of social disapproval or personal discontent with a person on the ground of their unique characteristics, which is judged as a sign of disgrace and something that sets a person apart from others. Goffman (1990) defined stigma as “the process by which the reaction of others spoils normal identity”. Goffman described three forms of stigma: the experience of a mental illness, physical deformity and association with a particular race, religion or belief. Stigma derives from deeply ingrained individual and social attitudes and always leads to discrimination. Negative attitudes and stigma directly affects the clinical practice in psychiatry (Byrne, 1999). Stigmatization of individuals with mental illnesses is widespread (Chowdhury et al., 2001; Jadav et al., 2007) and serves as a major barrier to proper mental health care and the better quality of life (Mann & Himelein, 2004; Charles et al., 2007). Reduction of stigma against persons with mental illness is a serious preventive work (Arboleda & Sartorius, 2008; Crisp et al., 2000) at all levels of mental health work- from clinic, hospitals, institution to community (Penn & Couture, 2002). World Psychiatric Association started an international programme to fight stigma and

discrimination against schizophrenia in 1996 and Royal College of Psychiatrist, London, completed an anti-stigma campaign (*Changing Minds*) with a five year (1998-2003) strategy.

3.6.3 Factors that facilitate cross-cultural communications

Cross cultural communication is the process of dealing with people from other cultures in a way that minimises misunderstandings and maximises the potential benefit out of therapeutic relationships. Payne (2004) provides some useful basic tips for effective cross-cultural communications. These are few important in a health service context: (a) *Slow Down* and speak clearly, normal pace, normal volume, no colloquialisms, or double negatives (i.e. 'not bad') ; (b) *Separate Questions*- short sentences one by one; (c) *Avoid Negative Questions*; (d) *Take Turns*- talk and listen; (e) *Write it Down*- for clarity if necessary; (f) *Check Meanings* - whether you are properly understood; (g) *Avoid Slang*; (h) *Be Supportive* - make the client comfortable, confident and trust you; (i) *Maintain Etiquette*- learn some cross-cultural issues before dealing a people from the target culture and (j) *Listen actively*: Listening is one of the most important skills in any communication, especially in the field of medicine (Robertson, 2005). The success of any therapeutic consultation depends on how well the patient and doctor communicate with each other (Gask & Usherwood, 2002). Following are the few rules to become an active listener: pay attention, avoid distractions, show that you are listening, engage yourself, provide feedback, defer judgment and respond appropriately. Some useful interview guides are shown in Box 1.

4. Clinical application of culture: Cultural assessment

4.1 Emic-etic perspective

Proper insight and understanding about culture's impact on mental health and treatment is crucially important to prevent disparities in assessment and treatment (Hwang et al, 2008). How we perceive the other culture is dependent on our view or looking lenses. There are two ways of looking at any given cultural system: Emic and Etic - terms coined by Kenneth Lee Pike, an American linguist and anthropologist in 1954 (Pike, 1967). These are linguistic terms- phonetic (sound of universal language) and phonemic (sound of specific language) respectively. *Etic* is used to address things that are considered universal, whereas *emic* is culture-specific. From clinical research point- an *emic* account is a description of behaviour or a belief that account comes from a person within the culture (insider). The *etic* approach implies that research is conducted by an outside observer. *Etic* approach may be more objective but may lose culturally relevant meaning in its interpretation. Emic-etic controversy in the research of culture and mental health is a long debate and challenge in psychiatry (Marano, 1982; Littlewood, 1998; Warner, 1999).

In their very influential publication on 'Culture and Psychiatry' Tseng and Streltzer (2004) very nicely summed up three basic areas of cultural interaction with the therapeutic system. These are:

1. *The culture of the Patient*: patient's understanding of illness, perceived cause, symptom experience and meaning and treatment expectations - all of which are being influenced by culture.
2. *The culture of the Physician*: pattern of attention, interaction and communication with the patient. Physician's culture explicitly or implicitly guides his/her attitude toward the patient, understating of the problem, support and treatment and care provision of the patient

3. *The culture of Medical Practice*: These are the framework of rules, regulations, customs and attitudes of the medical system and institutions in which the service to the client is provided. Tseng and Streltzer (2004) described it as "invisible cultural system" and in every society there are set rules for each medical disciplines and institutions, for its members and principles of care. All these culture-dependent medical customs influence doctor-patient relation and interaction (Tseng, 2003) and treatment expectations.

A. Explanatory Model of Distress: 8 questions of Kleinman et al., (1978)

1. What do you think has caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Will it have a short or long course?
5. What kind of treatment do you think you should receive?
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?
8. What do you fear most about your sickness?

B. LEARN model (Berlin & Fowkes, 1983) for physicians-in-training

- Listen with sympathy and understanding to the patient's perception of the problem
- Explain your perceptions of the problem and your strategy for treatment.
- Acknowledge and discuss the differences and similarities between these perceptions.
- Recommend treatment while remembering the patient's cultural parameters.
- Negotiate agreement. It is important to understand the patient's explanatory model so that medical treatment fits in their cultural framework.

C. FICA model (Josephson & Peteet, 2004): screening for worldview and spirituality

- Faith and religious/spiritual beliefs
 - Involvement in the practices associated with a faith or beliefs
 - Community of support related to a faith or beliefs
 - Address how these beliefs, practices, and community are to be integrated in health and mental health care
-

Box 1. Models of Effective Cross-Cultural Communication and Negotiation

4.2 Culture in mental health care

Group of Advancement of Psychiatry (GAP, 2002) clearly stressed the importance of culture in mental health and strongly advised that careful assessment of the cultural context of psychiatric problems must form a central part of any clinical evaluation. They categorized four areas of cultural importance in clinical psychiatry.

1. *Diagnostic and Nosological factor*: cultural competency training and cultural formulation in clinical assessment that enhances treatment and care planning.
2. *Therapeutic and protective role*: culturally determined attitudes and behaviour can operate as a cushion that prevents the occurrence of psychopathology and/or the spread of its harmful consequences. Role of extended families and social networks neutralize the impact of stigma, and traditional healing, role of religious beliefs and practices may enhance health recovery.

3. *Ethnopsychopharmacology*: Series of recent research has shown that there is a significant difference among ethnic groups in their response and vulnerability to side-effects of medications because of the genotypic variations, which influence the pharmacokinetics and pharmacodynamics of drug metabolism (Matthews, 1995). The role of cytochrome P450 enzymes in hepatic metabolism has been extensively studied (Lin et al., 1993). Asian patients often respond to substantially lower doses of psychotropics. Specific mutations of certain cytochrome P450 enzymes lead to poor or slow metabolism. Several ethnic variations in drug response has been documented, e.g., to neuroleptics (extrapyramidal side effects- Jann et al., 1989), Asian-Caucasians difference in tricyclic antidepressants serum level (Rudorfer et al., 1984); racial differences in red blood cell sodium and lithium levels (Hardman et al., 1998) and clozapine-induced agranulocytosis has been more commonly observed in Ashkenazi Jews, especially in those with a cluster of HLA types (Lieberman et al., 1990). Multiple psychosocial factors like gender, diet, consumption of cigarettes, caffeine, alcohol, herbs, psychoactive substances, sleep-activity-rest patterns and environmental-geographical effects influence ethnocultural differences in psychotropic drug metabolism and response (Jacobsen, 1994; Ng et al., 2008). Recent advances in genetic neuroscience; especially the psychosocial genomics (Box 2) unfolded a new horizon of understanding of culture/social-gene interactions: "how the subjective experiences of human consciousness, our perception of free will, and social dynamics can modulate gene expression, and vice versa" (Rossi, 2002a).
4. *Management and structuring clinical services*: Culture is an important element in the structure of management approaches and provision of services to the community. Three issues form the basis of this approach, viz., Cultural sensitivity, i.e. the awareness of culturally based needs in a given population, Cultural relevance, i.e. the implementation of measures that help to provide culturally sensitive services and Cultural competence, both of the organisation and its workforce to deliver the care in a culturally appropriate way.

5. The cultural formulation

Culture has a very important role in precipitating, perpetuating and preventive factors in relation to any illness (Bhugra & Osborne, 2006). The cultural assessment is thus helping providers understand where and how patients derive their ideas about disease and illness. Assessments help to determine beliefs, values and practices that might have an effect on patient care and health behaviors (Weiss, 2001). In fact, cultural assessment improves patient safety in healthcare organization (Nieva & Sorra, 2003). So Cultural Consultation service (Kirmayer et al., 2003) and Cross-cultural psychiatric assessment (Bhugra & Bhui, 1997) is now becoming a cornerstone of clinical assessment in multicultural health services and psychiatric training. Cultural formulation not only make the diagnostic process and treatment more culturally sensitive (Borra, 2008), but also becoming a part of therapeutic justice in the midst of growing cultural pluralism in recent societies (Lewis-Fernandez & Diaz, 2002).

5.1 DSM IV –Tr cultural formulation

APA published DSMIV in 1994 which included an 'Outline for Cultural Formulation' to provide a concise method of incorporating cultural issues into the therapeutic (diagnosis

Psycho-Social Genomics is the study of how psychological and social processes modulate gene expression and brain plasticity (Rossi, 2002a). Virtually it is an interdisciplinary field involving studies of stress, psychosomatics, psychoimmunology, psycho-neuro-endocrinology and psychobiology of creativity, optimal performance, dreaming, art, ritual, culture, and spiritual life. The main focus of psychosocial genomics is to explore how the levels of gene expression, neurogenesis, and healing are interrelated as a complex, adaptive system with the levels of human experiencing, behaviour, and consciousness (Rossi, 2002b). In other words, psychosocial forces and factors can shape neurobiology.

The contributions from psychosocial genomics have shown that socio-environmental experiences influence neurobiological structure and functions of brain across the life cycle (Garland & Howard, 2009). This is called '**Dynamic Gene Expression**': the interplay between behavioural state-related gene expression (nature) and activity-dependent gene expression (nurture) bring about healing through neurogenesis and learning (Hofmann, 2003). Investigations of neuroplasticity demonstrate that the adult brain can continue to form novel neural connections and grow new neurons in response to learning or training even into old age. The discovery that gene expression is not static, but rather is influenced in an ongoing way by interactions with the environment – has led to the interest in the influence of psychosocial treatments on illnesses that are thought to have strongly biological underpinnings (Rossi, 2004).

Box 2. Psychosocial Genomics

and care) process (Lu, 2006). The DSM-IV-TR (APA, 2000) Outline for Cultural Formulation provides a systematic method of considering and incorporating sociocultural issues into the clinical formulation. Depending on the focus and extent of the evaluation, it may not be possible to do a complete cultural formulation during the first interview. However, when cultural issues emerge, they may be explored further during subsequent meetings with the patient. In addition, the information contained within the cultural formulation may be integrated with the other aspects of the clinical formulation. Though there are some criticism of DSM IV and culture (Littlewood, 1992; Rogler, 1993) and cultural formulation (Mezzich et al., 2009; Thakker & Ward, 1998), yet DSM IV-TR outline for cultural formulation is the only relatively standard protocol till available for assessment of culturally diverse individuals (Lim, 2002). Kirmayer and colleagues from the Transcultural Psychiatry Group at McGill University, Montreal, Canada provided a very useful expanded version of DSM IV outline for clinical use (Kirmayer et al., 2008).

5.2 Content of cultural formulation (DSM-IV-TR):

Following is a brief description of the five components of Cultural Formulation framework of DSM IV TR (Focus, 2006):

1. *Cultural identity of the individual*: Usual focus is on ethnicity, age, gender, acculturation/biculturality, language (mother tongue and present use), socioeconomic status, sexual orientation, religious and spiritual beliefs, disabilities, political orientation, health literacy, migration, involvement with culture of origin and host culture.
2. *Cultural explanation of the individual's illness*: Usual focus is on patient's explanatory models or idioms of distress, perceived cause and cultural meaning of distress/symptoms, past help-seeking and present treatment expectations and preferences.

3. *Cultural factors related to psychosocial environment and levels of functioning*: involves information on available social supports, levels of function or disability, the roles of family/kin systems and religion and spirituality in providing emotional, instrumental, and informational support.
4. *Cultural elements of the relationship between the individual and the clinician*: This include the ethnocultural identity and social status of physician, language, knowledge about the client's culture, transference and countertransference issues, cross-cultural skill and ability and eagerness of the physician to understand client's problem form his/her cultural context.
5. *Overall cultural assessments*: how the cultural assessment will apply to diagnosis, treatment planning and care.

Cultural formulation should be as exhaustive as possible and the health professional should maintain a detailed note with ample narratives. It needs a special session to work out. Following is a brief interview note (Table 2) which may be helpful in a busy clinic to keep relevant cultural note with the clinical record of the client.

Currently experimentations and clinical trials are ongoing with the Cultural Formulation protocol in different academic institutions including DSM V and ICD 11 working groups and it is hoped that shortly we will get a more comprehensive, easy-to-use clinical protocol that would be useful for assessment and treatment planning. Initiatives from different cultures and countries are necessary to gain more cross-cultural knowledge and to mitigate Eurocentric bias.

6. Conclusion

In recent decades the horizon of psychiatry, rather mental health and wellbeing has broadened to an unprecedented extent because of many challenging and fascinating inputs from medical geography (Holley, 1998; Mayer, 1996) and ecology (Carey, 1970; Gadit, 2009), medical sociology (Rogers & Pilgrim, 2010; Cook & Wright, 1995), medical anthropology (Kleinman, 1988; Fabrega, 1992; Gaines, 1992), psychology and neurosciences. There is a significant change in the medical ethics of therapeutic system and procedures with more focus on human rights, race relation and equality and diversity, and immigration health within a national standards and legal framework. Globalization and technological improvement facilitated population movement and created a multicultural cliental in every sphere of civil life, be it work place, industry, corporate or health service. So culture is now becoming a primary issue in all communication and policy frameworks. Medical teaching and training primarily focus core medical subjects, inputs from sociology, anthropology or other social sciences are virtually negligible. This is a global scenario. In recent years some universities and national health agencies highlighted the need for cross-cultural training and cultural competence in health care. This is a good sign. Some international health organizations like WHO, World Psychiatric Association, American Psychiatric Association, Royal College of Psychiatrist, European Psychiatric Association, Society for the Study of Psychiatry and Culture and others are also advocating this need very proactively. A dozen of very scholarly journals dedicated to culture and mental health, to name a few, Culture, Medicine and Psychiatry, Transcultural Psychiatry, World Cultural Psychiatry Bulletin, International journal of Culture and Mental Health, Mental Health, Religion and Culture, Anthropology and Health Journal, Anthropology and Medicine, Ethnicity and Health, Journal of Immigrant and Minority Health, International Journal of Social Psychiatry etc. are

also taking the cultural issues in the forefront of medicine and mental healthcare, and thus enriching our perception, attitude and thrust for cross-cultural knowledge in a very positive way. In recent decades quite a large number of books on culture and health (mental health) has been published and helped us to develop our therapeutic ambience in a more culture-conducive way. Cultural diversity, competency and cultural formulation has become a part of health care delivery system (Anderson et al., 2003) and medical education (Marzan & McEvoy, 2010) and psychiatry training programme (Lu & Primm, 2006) in some of the universities and health care organizations. It is now well evidenced-base that cultural competency in health care in general and mental health care in particular is a ethical, legal and clinical requirement (Johnson & Cert, 2004) which in turn prompted more health service research and culture-ethnicity-health studies in academia (Skultans & Cox, 2000; Lopez & Guarnaccia, 2000). But unfortunately this momentum in culture and mental health initiatives is observed mainly in the developed countries, significant progress in the developing part of the globe is still lacking. I am concluding with a valuable remark by Tseng (2006) regarding the aims, objective and the task of psychiatrists: "Historically, the study of culture-related specific syndromes prompted the development of transcultural psychiatry, and later, cultural psychiatry, as subfields of general psychiatry. However, clinically, instead of being overly concerned with how to consider and label more culture-related specific syndromes and debating how to categorize them diagnostically, we need to move ahead and concentrate on the understanding of the cultural implications of all forms of psychopathology and examine approaches to **culture relevant treatment**, that is, providing **culturally competent care for all patients**. This is a practical need that exists in contemporary societies, which are becoming increasingly multiethnic and polycultural." (emphasis by the present author).

7. References

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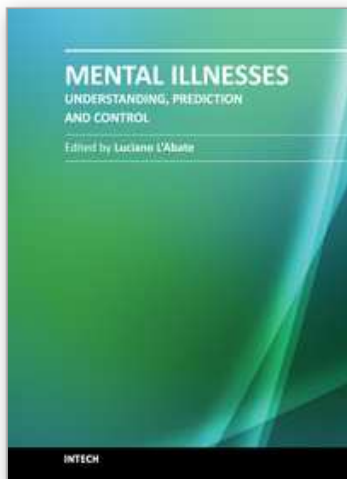
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In the book "Mental Illnesses - Understanding, Prediction and Control" attention is devoted to the many background factors that are present in understanding public attitudes, immigration, stigma, and competencies surrounding mental illness. Various etiological and pathogenic factors, starting with adhesion molecules at one level and ending with abuse and maltreatment in childhood and youth at another level that are related to mental illness, include personality disorders that sit between mental health and illness. If we really understand the nature of mental illness then we should be able to not only predict but perhaps even to control it irrespective of the type of mental illness in question but also the degree of severity of the illness in order to allow us to predict their long-term outcome and begin to reduce its influence and costs to society. How can we integrate theory, research evidence, and specific ways to deal with mental illness? An attempt will be made in the last conclusive chapter of this volume.

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