Culture and the Diagnostic and Statistical Manual: Fourth Edition

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Abstract

This paper will examine and review the current literatures’ demand for the inclusion of culturally sensitive and appropriate criteria into the existing descriptive and diagnostic protocols used in the diagnosis and treatment of mental health care service consumers from a culturally and linguistically diverse background in South Australia. The South Australian Mental Health Act 1993 fails to provide mental health care professionals with any reasonable definition of mental illness, but it relies upon the subjective interpretation of the existing diagnostic criteria by the attending mental health care professional. This paper will critically examine the often speculative but always controversial relevance of migration, post-arrival experiences and culture to the diagnosis and treatment of mental ill-health.

Introduction

There are a number of quite important omissions in the existing South Australian Mental Health Act (SAMHA, 1993). These include the contributing socio-cultural factors of the significant influence of culture and culturally determined behaviour, belief systems, and the dual concepts of honour and shame (Kirmayer, 1995: 509). All of these elements have a bearing on the possible reasons for an individual’s particular behaviour pattern at the time of clinical assessment (Grypma, 2001). The important issue of the perception and understanding by the individual of what they believe is responsible for their particular behaviour pattern will be examined in this paper within the cultural context of the culturally and linguistically diverse background (CALDB) individual. This is of intrinsic importance as it impacts directly upon the correct and culturally appropriate diagnosis of the mental ill-health condition of a CALDB individual consumer by the clinician, as well as their subsequent treatment and therapy.

Culture and Diagnosis of Mental Ill-health

An element of confusion and misunderstanding may exist in the clinician/client relationship at the time of presentation for the purpose of diagnosis and treatment. The mental health service consumer from a CALDB might be experiencing a personal degree of cultural and linguistic alienation and isolation which prevents or hinders them from fully participating in the South Australian host community (Bruxner, 1997: 540). This may have the undesired effect of discouraging them from the full utilisation of mainstream psychiatric health care services (Barnett, 1993: 7-8). A personal perception or feeling of social isolation from the South Australian community may be further exacerbated by the pre-existing personal life stresses and traumas to which they have been subjected (Minas, 1992: 9). Compounding their perceptions of life’s difficulties they may also be the demands of the pre- and post-migration experience and the problems associated with adjustment and acculturation (Minas, 1992: 9).

It is possible that at the time of physical and psychiatric assessment by mental and general health care professionals, the individuals presenting before them might be exhibiting a mode of behaviour which could be a manifestation of the psychological and linguistic difficulties which they are experiencing. These psychological difficulties may express themselves in apparent clinically inexplicable physical or somatic symptoms (Escobar, 1995: 555).
The implications arising from this are of particular significance to the formulation of the Diagnostic and Statistical Manual: Fourth Edition (DSM-IV) (American Psychiatric Association, 1994), the International Classification of Disorders: Version 10 (ICD-10) (WHO, 1992), and to an extent, the South Australia Mental Health Act (SAMHA 1993). The risk and incidence of misdiagnosis as a result of using culturally inappropriate and standardised descriptive classifications and diagnostic nosology for mental disorders is of an unacceptably high level (Grypma, 2001). For example, “Cultural beliefs may make unusual symptoms salient and clinicians unfamiliar with local idioms of distress may be misled, at times to the extent of considering such patients psychotic” (Kirmayer, 1995: 509).

In view of the additional cultural and background information that the clinician might obtain from conducting a number of exploratory interviews with the CALDB mental health service consumer (Grypma, 2001), this professional and culturally appropriate form of client/doctor reciprocity could result in the preservation and protection of the fundamental dignity, worth and rights of an individual from a minority non-English speaking community group (Artiola, 1998: 121). Jayasuriya has suggested that if all clinical consultations were actively conducted using this culturally inclusive approach then the clinician would notice “the distinction between the severely ill and those experiencing ‘problems of living’ and avoid the medicalisation of all aspects of mental disorder” (Jayasuriya, 1992: 13). Waldegrave suggests that:

…cultures carry within them history, beliefs, ways of doing things, and processes of communication. Experience of the most intimate events and the most public are interpreted to the people, to some considerable extent, by their culture: culture by its very nature, gives meaning to events and experience (Waldegrave, 1990: 15).

He goes on to say that:

..this, in our view, requires of the therapist a qualitative appreciation and informed knowledge of a particular culture if therapy is to be successful in an ongoing sense. --- the therapist cannot continue to categorise clinical knowledge separately from cultural, socio-economic or gender knowledge. --- The therapist must be informed in all these areas and ensure that they are included in the therapeutic conversation (Waldegrave, 1990: 15-25).

However, the inclusion of this professional practise does not appear to form any part of the legislative objectives of the South Australia Mental Health Act (Grypma, 2001), although this is not to say that such issues are, therefore, ignored by clinicians.

Culture and the DSM-IV

In the early 1900s, Emil Kraepelin conducted a specific investigation of cultural aspects of mental ill-health. His research tended to focus upon the question of whether or not:

Western conceptions and diagnosis of psychiatric conditions were congruent with interpretations of similar conditions in non-Western societies; and whether there was any physiological basis to support the existence of wholly different psychiatric entities that appeared from time to time in non-Western cultures (ie., culture bound syndromes) (NSMRC Project 1, 1997: 14).

The findings of his own research appeared to indicate the existence of culture-specific syndromes, but he concluded that they were simply mirror-images of named diseases in the West.
The question of the extent to which culture affects the expression, prevalence, understanding and treatment of mental ill-health in the community is one that has been frequently pondered over by the members of the American Psychiatric Association (APA) for the entire development period of the DSM, since its very first publication in 1952 (Agbayani-Siewert, 1999: 19). Agbayani-Siewert makes the suggestion that the very fact that this question is being asked “reflects a critical tension in scientific investigations of mental health and illness” (Agbayani-Siewert, 1999: 19).

The DSM is popularly used by clinicians, psychiatric researchers and social scientists alike, but for varying purposes (Agbayani-Siewert, 1999: 19). White and Marsella suggest that the DSM:

…assumes that mental disorders are discrete biomedical entities that are explained by biomedical processes. It is often implicitly assumed that psychiatric symptoms or syndromes are universally distributed and uniformly manifested. This assumption is unwarranted, because groups vary in how they define such constructs as “distress”, “normality”, and “abnormality”. These variations affect definitions of mental health and mental illness, expressions of psychopathology, and coping mechanisms (White & Marsella, 1982: 38).

White and Marsella appear to be suggesting that the DSM is taking a dichotomous approach to mental health as reflected in their statement that it “assumes that mental disorders are discrete biomedical entities that are explained by biomedical processes”. This interpretation of the document is contested by Kalucy, who states that, in his experience, most practicing clinicians take both a biomedical and a psychosocial approach to the diagnosis of mental ill-health (Kalucy, 2001).

The importance of culture to the development of the “normal” personality appears to be relatively uncontested. However, there is a lesser degree of concurrence between the cultural relativist authors who “contend that explanations of mental illness cannot be separated from the individual’s social and cultural context” (Kaplan, 1998: 632) and the universalists who state emphatically that “a biological similarity and unity among people supersedes culture” (Agbayani-Siewert, 1999: 20). The issue of culture, and the way this influences the psychopathology of personality is even more contentious (Kalucy, 2001). This is especially so when suggestions as to how to appropriately measure these possible affects are discussed (Kirmayer, 1989: 328).

During the drafting of the final version of the DSM-IV, the Culture and Diagnosis group, sponsored by the National Institute of Mental Health (NIMH), presented a brief history of cultural considerations for inclusion in the DSM-IV to the American Psychiatric Association’s “task force”. They suggested the inclusion into the DSM-IV of the effects of culture and cultural diversity on personality disorders (PDs) (Alarcon, 1996: 260). This is particularly significant to the somatoform disorder section of the DSM (Kaplan, 1998: 629-643). A subsequent analysis of the DSM-IV reveals a quantitative acceptance level of the recommended cultural suggestions to be included in the DSM, of only 27%. When a specific study of 10 personality disorder types is conducted, this figure rises to 51% (Alarcon, 1996: 260). Alarcon makes the suggestion that most of the group’s recommendations were included in the DSM-IV when directly related to paranoid and schizoid personality disorders. However, they were omitted or “almost totally ignored” (as were the conceptually important cultural dimensions of self-image, contextualization, acculturation, exclusionary criteria, and differential diagnosis for other PDs such as narcissistic, histrionic, and avoidant) (Alarcon, 1996: 260). The understandable response by Alarcon to the apparent uneven distribution of cultural factors included in the DSM-IV, is to call for a greater level of theoretical debate, an
increase in research, and clinical observation “in order to make the cultural perspective more visible and relevant to the national mental heath debate” (Alarcon, 1996: 260).

The inclusion of cultural, social and environmental influences as determinants of individual patterns of behaviour, is not to be limited to the personality disorder, or borderline personality disorder section of the DSM-IV or the ICD-10. Individuals who present before a clinician with a mental ill-health condition which has subsequently been diagnosed as a severe psychosis such as: chronic schizophrenia psychosis, schizoid affective psychosis, paranoid states, senile and pre-senile organic psychotic conditions (Burdekin, 1993: 45; Barrett, 1997: 365-379), also exhibit contributing factors which may possibly be best explained within the cultural context of the life of the individual (Westermeyer, 1985: 798-804). The perception and understanding of the distress which an individual relates to the mental health professional upon presentation in an attempt to explain their symptoms, may take the form of a story, the contents of which may not be quite what is generally expected by the clinician (Barrett, 1997: 481-496). The story is often comprised of a system of commonly held core beliefs, values, traditions, superstitions and experiences which are manifestations of their native culture (White, 1995: 112-123). Very often, the explanations provided by these stories have little or no comparative relevance in contemporary Western psychiatric medicine (Barrett, 1997: 481-496). Waldegrave is of the opinion that “therapists in Western countries have deluded themselves for long enough by dismissing this sort of information as irrelevant” (Waldegrave, 1990: 16).

Therefore, it may not be given the appropriate amount of due consideration, respect and understanding that it deserves, with the condition incorrectly described and categorised in both the DSM-IV and the ICD-10 (Artiola, 1998: 121). This is despite the claim of the DSM to be conceptually flexible and culturally sensitive, in encouraging clinicians to adopt a more culturally and linguistically appropriate procedural methodology in the diagnosis of mental ill-health, with the nominal inclusion in the nosology of the non-biological, environmental and social causational factors of mental ill-health (Terranova-Cecchini, 2000: A67). Arnold and Matus draw attention to the fact that in 1991 the American Psychological Association (APA) developed Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 1991):

…to focus awareness on the special vigilance that must be paid in providing services to individuals from different cultures, and individuals different from those on whom assessment instruments were originally developed and nomed (Arnold & Matus, 2000: 121).

For example, in the Somatoform Disorder section of the DSM-IV, it states that “the type and frequency of somatic symptoms may differ across cultures” and that “Accordingly, the symptom reviews should be adjusted to the culture” (APA, 1994: 447). However, the manual continues with a clarification of the previous statement, that “the symptoms listed in this manual are examples that have been found most diagnostic in the United States” and that “It should be noted that the order of frequency was derived from studies done in the United States” (APA, 1994: 447).

Almost as an afterthought, the manual makes the admission, that despite the fact that “Somatization Disorders occurs only rarely in men in the United States...the higher reported frequency in Greek and Puerto Rican men suggests that cultural factors may influence the sex ratio” (APA, 1994: 447). Although the DSM-IV acknowledges the relevance of culture and encourages attending clinicians to recognise and consider culturally determined behaviour and idiosyncrasies in the cultural formulation section of their diagnosis, the manual does appear to place the burden of effort for the culturally correct, appropriate and sensitive diagnosis and treatment of CALDB individuals upon the discretion of the attending clinician or mental
health care professional as there is no specified requirement for the clinician to follow the cultural recommendations of the manual (APA, 1994: 447).

The significance of the inclusion into the DSM-IV nosology of a frequently applied culturally sensitive and linguistically appropriate method of diagnosis and therapy is paramount in view of the increasing levels of exposure for mental health service consumers to the diagnostic and treatment protocols contained within the DSM-IV. Arnold and Matus make the suggestion that: “In order [for psychiatry] to provide effective and useful diagnostic and treatment protocols to the variety of consumers in the population, [psychiatry] must have more than just awareness” (Arnold & Matus, 2000: 121-122). Morrissey makes the point that:

...an adequate response to cross-cultural factors in health service delivery involves a lot more than the possession of cultural knowledge on the part of the health service provider. It will also involve a willingness to negotiate changes in the traditional culture of the health service delivery itself (Morrissey, 1997: 16).

He goes on to argue that:

Knowledge of the culture of a particular group of people (ethnic or other) which is valid in the sense of assisting in improving the quality of care can only be acquired through the empowerment of that group to define its culture(s) for itself. This means essentially, empowerment to define a process at a particular time and in a particular place (Morrissey, 1997: 16).

This is of particular significance in view of the emphasis currently placed upon the role of the DSM-IV in the provision and delivery of mental health care to the community (White, 1995: 115).

Interaction-Management Information

Waldegrave argues that “culture is the most influential determinant of meaning in people’s lives” (Waldegrave, 1990: 19). Truth is a subjective concept which is generally validated by individuals through their cultural beliefs (Waldegrave, 1990: 19). Waldegrave also suggests that:

...cultures express the development of humanity and cooperation of groups of people over long periods of time. As such they are sacred and worthy of the greatest respect. Cultures are not learned or understood by scientific observation, but experienced by living. People who are from a particular culture can articulate the processes and finer nuances of that culture (Waldegrave, 1990: 19).

The aetiology of a psychiatric disorder, such as schizophrenia, reveals that the contributing causational factors are often limited to our hegemonic psychiatric knowledge (White, 1995: 115-121). That is, the existing pathologising discourses have the tendency of scientising this knowledge (White, 1995: 115-120). In an attempt to discover the “truth” about diseases of the mind, pathologising discourses establish claims to an objective reality. According to White:

...pathologising discourses have the potential to bring to us a degree of comfort in a world in which it is becoming increasingly difficult to find this. As such, they assist us to avoid the acknowledgment of the fact that these problems are very significantly of our culture, that these problems are products of our modes of life and of thought --- the discourses of pathology make it possible for us to ignore the extent to which the problems for which people seek help are so often mired in the structures of inequality of our culture, including those pertaining to gender, race, ethnicity, class, economics, age, and so on (White, 1995: 115).
Neither biological nor cultural factors can be regarded as the sole determinants of mental ill-health in an individual (Kalucy, 2001). The importance of each should not at any time in the diagnosis and therapy process be underestimated. Rather, they should at all times be accorded the correct degree of respect and dignity they deserve for the contributing role that they both play in the onset of mental ill-health in an individual. Indeed, the best diagnostic and therapeutic outcomes for both the mental health service provider and consumer may only be achieved when this is the case.

Psychiatric case studies, using the principles of narrative therapy (Wylie, 1994: 40-42), conducted in South Australia by Adelaide based mental health care professionals, demonstrate and document the benefits and difficulties when a dualistic approach is taken by the clinician at the time of assessment of mental health service consumers from a CALDB. The conversations between the clinician and client were sometimes conducted in the presence of an interpreter in an attempt to overcome any difficulties or barriers caused by differences in language and culture between the mental health professional and the consumer (Grypma, 1997: 4-7).

After investigating a number of clinical case studies, which took the form of a transcript of the clinician/client conversation at the time of assessment, it became clear that individual understandings, perceptions and causes of sickness and ‘abnormal’ behaviour are not to be regarded as being specific to any one particular ethnic group, culture, religion or belief system (Arnold & Matus, 2000: 121-123). The one commonality in each of the cases investigated was the existence of some form of ‘abnormal’ behaviour. However, the explanations given by the client for the cause(s) for their specific behaviour pattern were varied and often found to be influenced by socio-cultural and environmental factors (Arnold & Matus, 2000: 121-123). The consumer was permitted, by the clinician, to speak freely about the personal and cultural perceptions of their sickness with the result that they often related their explanations in the form of a simplistic story. For example, in a number of cases, but not all, the clinician would listen to the cultural explanation that the client related to them, and then include the story in the cultural formulation section of the diagnostic assessment (Barrett, 1997: 371-379; Streit, 1998: 451-463; Ikels, 1998: 262-280; Cheung, 1997: 250-258; Barrett, 1997: 486-496). The relevance of this procedure is for the clinician to gain a greater understanding of the client’s cultural perceptions of what is happening to them. This would then, presumably, lead to increased levels of trust and reciprocity in the clinician/client relationship, resulting in a more effective and satisfactory diagnosis and treatment of the client’s condition.

The importance of a full exploration of a client’s circumstances in the correct diagnosis of an apparent mental ill-health condition can not be overstated. Similarly, for clinicians to achieve a culturally appropriate and sensitive psychiatric assessment/diagnosis of CALDB mental health service consumers, there must occur a level of reciprocated understanding between the clinician and client gained through the medium of a meaningful exchange of ideas and emotions conveyed in the conversational dialogue of an assessment interview.

**Linguistic Diversity and Competency: Government Policies and Service Guidelines**

Language is conventionally divided into phonological (sound), semantic (word) and syntactic (grammar) domains (Chomsky, 1965: 28). Chomsky refers to linguistics as “universal rules common to all languages” (Chomsky, 1965: 28-29). Sledge et al. make the point that “when one considers deviant speech it is important to differentiate between performance and competence” (Sledge, et al., 2001: 373). That is, performance refers to the application of the language rules by the individual, within specific situations, and may include non-linguistic contributing factors to the production and reception of the speech act (Sledge, et al., 2001: 373). For example, such factors as exhaustion and memory limitations (Sledge, et al., 2001:
In contrast to performance, competence is concerned solely with the measurement “of the individual’s mastery and knowledge of his or her language” (Sledge, et al., 2001: 373). Competence, therefore, refers to an individual’s linguistic capacity (Chomsky, 1965: 28-29). South Australian mental health professionals specifically use the diagnostic tool of linguistic competence, within an interview/conversation setting (Henton, et al., 2001: 315), to determine the presence of a mental disorder as stipulated in the South Australian Mental Health Act 1993 (SAMHA, 1993: 3). Therefore, any failure, or language deficit by the CALDB individual to effectively articulate, or express, their personal mental health well-being to a clinician at the time of assessment could increase the risk of misdiagnosis. The possibility of misdiagnosis may be further increased should there occur a receptive deficit in the linguistic and cultural abilities of the attending mental health care professional.

According to Grypma, “language is the main mediating mechanism between the individual and culture” (Grypma, 1997: 5). Language is the principle medium of cultural transmission of meaning. In other words, “culture and language are inextricable from the person’s cognition, effect and behaviour, conscious or unconscious” (Grypma, 1997: 5). The concept of language deficits in both performance and competence are also incorporated in the ICD-10 definitions of personality disorder and its subtypes.

An example of the recognition and acknowledgment by the Federal Government of the fundamental significance of culture and language to the diagnostic procedural methodology used in the clinical assessment of mental health consumers from a CALDB is evident in clause 11.3.9 of the “National Standard for Mental Health” (Comm of Aust, NSMH, 1996). The mandatory guideline for the development of Mental Health Services in all states and territories of Australia specifies that: “There is opportunity for the assessment to be conducted in the preferred language of the consumer and their carers [with the] use of accredited interpreters, bilingual counsellors, transcultural mental health services” (Comm of Aust, NSMH, 1996: 22). Clause 11.3.10 specifies that: “Staff are aware of, and sensitive to, cultural and language issues which may affect the assessment. Staff specialised in transcultural mental health either conduct the assessment or guide the work of other clinicians” (Comm of Aust, NSMH, 1996: 22). This statement is an elaboration on the previously mentioned Recommendation 14 of the 1978 Galbally Report, with an additional acknowledgment of the important work and services currently being performed by members of the Australian Transcultural Mental Health Network (ATMHN) for the provision and delivery of culturally and linguistically appropriate mental health services to CALDB consumers.

Any form of pronounced deficit in English language proficiency during psychiatric assessment, diagnosis and treatment can be detrimental to an individual mental health consumer from a CALDB. According to Minas, “the first impediment is the lack of a common language between [mental health service] providers and users” (Minas, 1988: 105). However, linguistic communicative deficiency is not the only impediment to a clinician/consumer conversation. Information may be transmitted, or conveyed, through the unconscious use of the entire body in order to establish effective communication (Bullivant, 1977: 107-113), in particular, with the use of facial expressions and gestures (Jayasuriya, et al., 1992: 3).

The transference of cognitive information by means of linguistic communication between the consumer and the attending clinician may still be affected by cultural difference. That is, a modicum of misunderstanding and confusion may still exist even between two people who share the same language, but have different cultural backgrounds because neither paralinguistic nor extra-linguistic communication is common to all cultures. The way of gesturing, facial expressions, tone of voice, how to start or end a conversation, together with many other communicative behaviours differ from culture to culture (Taylor, 2001: 325-333;
Henton, et al., 2001: 312-319). This is one of the fundamental difficulties experienced on a daily basis in the clinician/consumer relationship with the engagement and intervention of the professional interpreter.

Hall hypothesises that each language reflects the cognitive system and thought of the people who speak it. That is, “language is more than a medium for expressing thought, being a major element in the formation of thought” (Hall, 1966: 1-2). Therefore, such differences are observed in vocabularies, and grammatical systems such as punctuation and expression. For example, there is no English language equivalent that corresponds with the Japanese word of amae because the concept is peculiar to Japanese. In Japanese, this word means “pervasive wish for benevolent attention and treatment from others without personally exerting oneself” (Tatai, 1983: 12-45). In turn, the English word of privacy cannot be translated into Japanese because the Japanese do not have the concept of privacy (Tatai, 1983: 12-45).

Difficulties also arise in linguistic cross-cultural communication with the culturally different concept/meaning of the same word. For example, in the World Health Organisation Self-Report Questionnaire (SRQ), a psychiatric screening instrument applied to cross cultural settings, a discrepancy occurred between the client’s interpretation of the questionnaire and that of the clinician (Minas, undated: 3-7). Respondents from Ethiopia were asked if they ever “slept badly” or had a “poor appetite”. While “sleeping badly” in the SRQ means to suffer from insomnia, the respondents interpreted it to mean “having a nightmare” or “sleep walking” because the concept of insomnia does not exist in their culture. The question about poor appetite could not be answered by the Ethiopian respondents due to their social condition in which they have to “wage a daily struggle to survive” (Minas, undated: 3-7). The relationship and level of understanding between the respondent and the clinician, essential for the purpose of making a correct diagnostic classification of the patient’s state of mental wellbeing, can be affected as a result of the communication difficulties experienced.

Interpreters are often brought in and utilised in a face-to-face interview in an attempt to overcome or bridge the language difficulties. However, misinterpretation sometimes occurs as expressions of emotional states are often delicate and ambiguous, and therefore, slight differences between what the patients say and their translation and misinterpretation could bring about misdiagnosis (Kryon, undated: 62). Misinterpretation is generally found to occur more frequently when interpreting from patient to clinician, especially when the patient is experiencing a degree of psychosis (Price, 1975: 263-267). However, the frequency of misinterpretation was almost always found to be greater in interpreting from patient to clinician than vice versa, without the presence of psychosis. Minas suggests that many difficulties are still yet to be overcome with the presence at the assessment interview of a professional interpreter (Minas, 1990a: 78-90). The misinterpretation of behaviour distorts a correct evaluation of the patient’s emotional state and the severity of psychopathology. As a consequence, this could lead to ineffective treatment, such as unnecessary drugs/medication, or excessive electro-convulsive therapy (ECT) (Minas, 1990b: 250-281). Emotional/cultural relatedness is also a significant barrier for appropriate diagnosis and treatment. The breakdown of a CALDB individual’s emotional state often occurs as a direct result of events experienced by the person. The meaning and significance of such events are dependent upon the norms and values of the person’s culture, that is, these are “culture-bound Syndromes” (Parsons, 1990). In this way, the ineffectiveness of therapy is further aggravated by the inapplicability of the diagnostic criteria of Western psychiatry (Reser, 1991).

Cultural and communication barriers are not the only cause for existing problems with psychiatric treatment in Australia. Differences in attitudes towards, and the meaning of, mental ill-health, particularly as it relates to stigma and shame, also contribute significantly to the reluctance of CALDB consumers to adequately utilise psychiatric health care services, and
will be investigated later in this paper (Jayasuriya, 1990). However, an examination of the crucial Somatization and Dissociative Personality Disorder section of the DSM-IV, and its relevance to the correct assessment of CALDB consumers of mental health care services, follows next.

Somatization and Dissociative Disorders

Of particular significance to the diagnosis and treatment of mental ill-health and the provision and delivery of a culturally and linguistically sensitive and appropriate mental health service is the Somatoform Personality Disorder section of the DSM-IV. This classification of mental disorder may, or may not, include a psychosis or psychotic episode. Somatizing syndromes have been chosen here because the symptoms appear to be heavily influenced by the non-medical/biological factors of race, ethnicity and cultural background, and because the classification of symptoms which makes up many of the disorders “can be construed as idioms of distress in many cultures” (Brown, et al., 1999: 171; Escobar, 1995: 559). The term developed from the findings of Western medical research:

...and draws meaning from psychodynamic theories which posit that the repression of emotional disturbance culminates in the emergence of physical symptoms that mask the original intrapsychic conflict (NSMRC Project, 1997: 13).

The causes for many of these “culture bound syndromes” (Hall, 1966) are sometimes speculative but always controversial. The best prescription for the treatment and therapy of many of these disorders is often to listen to the explanations of the condition offered by the consumer themselves, using the principles of narrative therapy. For example, the syndrome Ataque de Nervios, described by individuals who have migrated to New York from Latin America and the Caribbean, appears to “follow stressful events and includes a cluster of somatization symptoms, as well as dissociative symptoms together with rather dramatic behaviour correlates” (Escobar, 1995: 564-565). Despite these people having been initially diagnosed as afflicted with a mental disorder, it has been suggested that individuals who present before a medical practitioner with somatoform physical symptoms may be doing so as a legitimate physical expression of the psychological and emotional difficulties caused by their post-migration adjustment and settlement experiences. Swarz has suggested that these people often use these somatoform symptoms as a reason to enter the health care system, thus avoiding the stigmatisation of mental illness (Swartz, et al., 1991; Escobar, et al., 1989).

Escobar suggests that the most common symptoms of somatization are gastrointestinal complaints and abnormal skin sensations (Escobar, 1995: 564). However, the results of the Epidemiological Catchment Area (ECA) survey into the psychiatric status of the general community revealed that the most common somatoform symptoms were gynaecologic (painful menstruations), gastrointestinal (excessive gas - abdominal pain) and cardio-vascular (heart palpitations - chest pain) (Goldberg and Bridges, 1988, Escobar, et al., 1987). According to the diagnostic requirements of the DSM-IV for somatoform disorder, the onset of symptoms generally occurs before age 30 years, and is:

...commonly associated with other mental disorders, including major depressive disorder, personality disorder, substance-related disorders, generalized anxiety disorder, and phobias. The combination of these disorders and the chronic symptoms results in an increased incidence of marital, occupational, and social problems (Kaplan, 1998: 632).

There are five specific and two non-specific somatoform disorders recognised in the DSM-IV, for which there are no known causes (Escobar, 1995: 556). The Somatoform disorder section of the DSM-IV is the only part of the nosology which includes cultural/social factors in the
diagnosis and treatment of mental ill-health (Kaplan, 1998: 632). The DSM-IV categories for the five specific somatoform disorders include:

1) Somatization Disorder, is a polysymptomatic disorder that begins before age 30 years, extends over a period of years, and is characterized by a combination of pain, gastrointestinal, sexual, and pseudoneurological symptoms.

2) Conversion Disorder, involves unexplained symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other general medical condition. Psychological factors are judged to be associated with the symptoms or deficits.

3) Pain Disorder, is characterized by pain as the predominant focus of clinical attention. In addition, psychological factors are judged to have an important role in its onset, severity, exacerbation, or maintenance.

4) Hypochondriasis, is the preoccupation with the fear of having, or the idea that one has, a serious disease based on the person’s misinterpretation of bodily symptoms or bodily functions.

5) Body Dysmorphic Disorder, is the preoccupation with an imagined or exaggerated defect in physical appearance (APA, 1994: 445).

There are also two further residual categories for somatoform disorders, the symptoms of which do not fit precisely into those already outlined. The first of which is the Undifferentiated Somatoform Disorder, with symptoms that have been present for a period of six months or longer, and have not been described elsewhere in the document. The second is the Somatoform Disorder Not Otherwise Specified category, in which the duration of symptoms is shorter (APA, 1994: 445), and they do not meet or fit into any of the previously mentioned somatoform disorder categories (Kaplan, 1998: 629).

The ICD-10 and the DSM-IV categories for somatoform disorders are very similar, with only subtle variations in classification. For example, the body dysmorphic disorder in the ICD-10 is classified as a subcategory rather than a full category. The ICD-10 also has neurasthenia as a separate category of diagnosis, the symptoms of which appear to overlap the DSM-IV categories for anxiety, depression, undifferentiated somatoform disorder, chronic fatigue and loss of appetite (Kaplan, 1998: 647). However, the ICD-10, includes somatoform disorders within the neurotic and stress-related groupings (F40-F48) (France, 2001: 35).

Both young and old CALDB mental health service consumers may undergo, or exhibit, one or more of the stress related symptoms as outlined in the DSM-IV and the ICD-10. This is often as a direct result of the difficulties and stress they have personally experienced during the pre- and post-immigration phases, with settlement services in Australia, English language proficiency, adjustment and acculturation (Blignault, et al., 1998: 11-12).

Aetiology
The aetiology of somatoform disorders involves several differing interpretations of the psychosocial formulations for the causes of the disorder (Kaplan, 1998: 632). That is, interpretations of the cause involve the symptoms as a type of social communication “the result of which is to avoid obligations, to express emotions, or to symbolize a feeling or belief” (Kaplan, 1998: 632). The emphasis that is placed upon the perceived contributing factors to the onset of the disease varies with the analytical viewpoint that is taken. For example, psychoanalytical interpretations of the symptoms are based upon the hypothetical premise that the symptoms are a substitute for repressed instinctual impulses. However, the behavioural perspective for the causes for the disorder, places a greater emphasis on the fact that somatization is a learned phenomenon, with parental teaching, parental example, and ethnic mores responsible for why some children exhibit these symptoms more frequently than
do others (Kaplan, 1998: 632). Kaplan makes the statement that some “patients with somatization disorder come from unstable homes and have been physically abused. Social, cultural, and ethnic factors may also be involved in the development of symptoms” (Kaplan, 1998: 632). The causational factors associated with Somatoform disorders may be as a result of a convergence of both the psychoanalytical interpretation and the behavioural perspective. Our concern here, however, is possible ethno-cultural contributing causational factors and the impact of these on assessment.

**Cultural Explanations of Illness**

The formulae for the effective construction of culturally sensitive and appropriate assessment and diagnosis of the mental health service consumer from a CALDB is designed to enable the mental health care professional to achieve the correct understanding from the client’s perspective. Therefore, it necessarily includes such essential data as the client’s “Cultural Identity”, “Language”, “Cultural factors in development”, “Involvement with culture of origin”, and “Involvement with host culture” (Streit, et al., 1998: 451-463). The information obtained from the client during the course of the initial, and subsequent early interviews, permits the clinician to observe, consult and assess the client within the correct cultural framework. Although these particular cultural factors appear to be relatively consistent in almost all of the case studies investigated, variations and modifications to the formulae sometimes occur (Ikels, 1998: 274-279). The second part of the formulae consists of the cultural explanations given by the consumer, and related to the clinician in attendance, of what they believe is causing their distress. On completion of the cultural formulation of the sickness, the clinician proceeds to make an overall cultural assessment of the condition. The cultural explanations obtained from the client often includes mythology and mysticism as part of their system of beliefs (Tapping, 1990: 44-45). Geist makes the point that:

> …all cultures have beliefs about health and illness that have been passed down from generation to generation. The difference between the belief system of the Western biomedical model and that of the other cultures can result in inappropriate assessment or complications in treatment and communication in the provider-patient relationship (Geist, 1994: 314).

Tapping suggests that “the therapist must be informed in all of these areas and ensure that they are included in the therapeutic conversation” (Tapping, 1990: 25). It is possible that only when this cultural and background information is used in conjunction with existing Western scientific mental health nosologies, that an effective and culturally appropriate medical tool in the diagnosis and treatment of clients from a CALDB can best be assured and the risk of misdiagnosis and treatment lessened.

**Concepts of Honour and Shame**

Differences in attitudes towards mental ill-health, especially regarding stigma and shame, contribute significantly to the reluctance of CALDB consumers to adequately utilise psychiatric health care services. Traditionally, this trend was most identifiable when used in conjunction with the sparse numbers of Southern European migrants being admitted to South Australian mental health institutions, compared to other community groups within society. Presently, this trend is observed most notably among Asian migrants from Vietnam, Thailand, Cambodia, China, Korea and so forth. The concepts of stigma and shame associated with mental ill-health are all pervasive in their cultures. Their belief is that if an individual is diagnosed as having a mental disorder it will automatically mean a “loss of face”, not only for the patient but also for their family members (Sang, 1990; Bowman, 1984). They will be too
ashamed to face others. It is the belief in this attitude toward mental ill-health which contributes significantly to the rejection of the interpreter by the patient (Bowman, 1984).

Minas suggests that service utilisation and an effective treatment and therapy is blocked by these very same attitudes and beliefs (Minas, undated: 5). According to Minas, the value orientation of Western culture emphasises “individualism”, “future orientation”, “belief in man’s dominance over nature” and “doing” (Minas, undated: 5). These norms are antithetical to the Asian value systems, which include an emphasis on “family relationship”, “man’s powerlessness before the forces of nature”, “spontaneous being”, and “present-time orientation” (Minas, undated: 5). The difference is significant especially for elderly migrants, for whom traditional value orientation is more firmly rooted in their daily living than for younger generations. For example, Thomas and Balnaves point out that:

...time limited and work oriented professional behaviour is not understood by the Vietnamese elderly. Neutrality and objectivity tend to be translated as disinterest, coldness and disrespect (Thomas, 1993).

He also suggests that these elderly migrants are more likely to consult their friends, family or Buddhist monk than to consult a professional clinician. Culturally appropriate methods of mental health care service delivery which incorporate family therapy and community support have been recommended for improving the mental health care of Vietnamese by several researchers in Australia and the United States, especially taking into account the operating belief system of these people (Thomas, 1992: 16-20). Rees and Wallace cite the “appreciation of relief when feelings and emotions [which] have been bottled up for a long time” (Rees and Wallace, 1982: 61) by CALDB clients, are listened to and given the respect they deserve by the attending mental health care professional. They go on to say that this theme is often a common finding in the literature on service delivery to CALDB mental health consumers.

Conclusion

Based upon the anthropological view of culture, Transcultural Psychiatry focuses on alleviating the problems of the actual diagnosis and treatment of mental ill-health consumers from a CALDB. Many of the existing difficulties in relation to this area have been pointed out. These are mostly attributed to the barriers that presently exist between the clinician and CALDB consumer and they cover several dimensions. The barriers to the effective and appropriate clinical diagnosis and treatment of CALDB mental ill-health service consumers include non-biological social factors such as cultural differences, the means of communication, both linguistic and non-linguistic, the context from which mental ill-health occurs, assessment and diagnosis, Somatization and Dissociative Personality Disorders, and the attitudes toward mental ill-health and its treatment. These problems, coupled with the lack of information about available services, have resulted in the under utilisation of existing government and non-government mental health care facilities and agencies by CALDB migrants (Minas, 1990: 250-257). The net effect may be the aggravation of any current or pre-existing mental ill-health condition, due to neglect. It has been suggested that with the correct and appropriate psycho-social safeguards in place to protect the rights and welfare of the CALDB consumer, there could be a natural reduction in the diagnostic incidence/prevalence of Somatoform and Dissociative Personality Disorders in the CALDB community. The achievement of these objectives would be a significant step in the improvement of mental health care service delivery to CALDB consumers in South Australia. It would also allow for the further de-institutionalisation of mental health care services for CALDB consumer and promote the continuance of their mental health care treatment within a community mental health care setting.
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