

Clinical Case Conference

The Role of Culture in Psychiatric Care

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CASE PRESENTATION

History

Ms. A was a 55-year-old Hispanic American woman of Cuban extraction who was referred to me by a local Catholic priest for psychiatric assessment and possible treatment. Ms. A's symptoms consisted of early morning awakening, crying spells, loss of appetite, weight loss of approximately 20 pounds in 3 months, headaches, pain in the back of her neck, and suicidal ideations. The symptoms had appeared approximately 4 months earlier and had become progressively worse.

Two months before the appearance of Ms. A's symptoms, her mother in Cuba had suddenly died from a stroke at the age of 78 years. Shortly after her mother died, Ms. A began to blame herself for departing from Cuba at the age of 25 years and leaving behind her mother and father. In addition, Ms. A thought that she was not a good daughter and that her obligation was to stay in Cuba and take care of her parents during their older years. She also felt extremely guilty because she was not able to visit her mother after leaving Cuba or to be present during her mother's funeral. Furthermore, Ms. A felt that her symptoms and feelings were the result of God's punishment for the abandonment of her mother in Cuba.

Shortly after the appearance of Ms. A's symptoms, her daughter, a 31-year-old high school teacher, fully bilingual and bicultural, took her to see a psy-

chiatrist after they had consulted their family doctor about Ms. A's symptoms. The psychiatrist to whom Ms. A was referred was an American, highly respected in the community and trained in Canada. He did not speak Spanish, so he consulted with her in English. Ms. A, however, was able to speak and comprehend English fairly well. Moreover, she was accompanied to the consultation by her daughter, a second-generation Hispanic American who had no problem whatsoever in communicating with the psychiatrist and, when necessary, assisting her mother during the psychiatric evaluation. Permitting the daughter to be present in the interview had advantages and disadvantages. In a way, the participation of Ms. A's daughter provided an opportunity for support and assistance based on the extended family network system, which is very predominant in Hispanic communities. Her daughter's presence, however, also generated tensions for Ms. A because she was exposing her vulnerabilities in front of her daughter. Such advantages and disadvantages, related to clinical and cultural issues, need to be assessed in each occasion.

At the end of the visit, the psychiatrist told Ms. A and her daughter that the patient suffered from depression, that she needed to take antidepressants, and that he thought she would recover fairly well from her illness. He also prescribed fluoxetine hydrochloride, 20 mg p.o., in the morning with breakfast and gave Ms. A an appointment to come to see him again in 1 week.

Upon leaving the psychiatrist's office, Ms. A told her daughter that the psychiatrist was wrong, that she was not depressed, that her suffering was a punishment from God, and that she would neither take the medication prescribed nor return to see the psychiatrist. Two months passed, and her symptoms became progressively worse.

In addition, Ms. A began to experience suicidal ideations and told her daughter about them. The patient's daughter, who was becoming very worried about her mother's illness, decided to seek help through her local Catholic church; she consulted a local priest known to the family. The priest, after being apprised of the situation, called for a family meeting and counseled the whole family about the situation that they faced. Attending this meeting were Ms. A, Ms. A's husband, her daughter and son-in-law, as well as their two children, aged 4 and 6 years. During the meeting, the priest acknowledged Ms. A's guilty feelings and her thoughts that her illness was due to God's punishment for having abandoned her mother in Cuba. He prescribed a penance, which consisted of praying a rosary once a week for 8 weeks, and advised her to see me for a second opinion. I had been well acquainted with the priest for some time. Since Ms. A had been instructed by the priest to see me for a second opinion, she acquiesced to the request and asked her daughter to make an appointment with me.

Initial Assessment

When I saw Ms. A for the first time, she appeared very sad, tense, and somewhat tearful and anxious. She showed much guilt about the death of her mother, her inability to be present during her mother's funeral, and her thoughts of having abandoned her mother in Cuba. Ms. A had agreed to leave Cuba at the insistence of her husband, who wanted to leave because the Cuban government had already espoused a socialist ideology. In addition, they were both Catholics, and they did not want their 1-year-old daughter to be reared in a socialist country. While in Cuba, Ms. A had secured the equivalent of a master's degree in education (Escuela Normal)

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and was working as a grammar school teacher when she left the island. In the United States, Ms. A was not able to work as a teacher because the education degrees of the United States and Cuba were not reciprocal; therefore, she had dedicated herself to rearing her only daughter and to doing her housewifely chores. Ms. A had no siblings and denied any history of psychiatric illness, particularly depression, in her family. She denied ever having experienced an episode similar to the one that she now was suffering. She also denied ever having any surgical interventions or any major medical illnesses. She additionally denied any history of substance abuse or alcoholism.

The mental status examination showed that Ms. A's appetite was markedly diminished; that she had lost approximately 20 pounds; and that she suffered from early morning awakening, cried a lot, had experienced suicidal ideations (without any real plans to commit suicide) for about 4–5 weeks, felt easily tired, and complained of pain in the back of her head and neck. She was oriented to time, place, and person. She denied hallucinatory experiences and was not delusional. Her thoughts about God's punishment for the "abandonment" of her mother in Cuba were well within the boundaries of her culture. Her cognitive functions were intact, with the exception that her ability to concentrate was poor, as demonstrated by her inability to subtract seven from a hundred. Her capacity to abstract was intact, but her insight was limited. She showed no motor retardation.

Without question, Ms. A suffered from a major depressive episode. I told her 1) that it was most important to follow closely the instructions of her priest with respect to the penance he prescribed and 2) that she needed to go to church not only regularly (as she always did) but more often at this time. I also told her that I wanted to talk to her priest about her "suffering," as well as to her family doctor about her pains in the head and neck, and obtained her permission to do so. I prescribed no medications and told Ms. A that I would call her after I had spoken with her priest and her family doctor.

Subsequently, I called her family doctor and discussed with him the origin of her head and neck pain. He thought that she did not have any objective organic reasons for these symptoms, and we both agreed that this type of pain was an integral part of depressive symptoms usually seen among

Hispanic American patients, particularly women (1, 2). I also conferred with Ms. A's priest, and he understood very well the patient's need for psychiatric care at this time. We also agreed that he would tell her to continue to see me as well as him. The priest later called her and discussed the necessity of her continuing to see both of us; when I called Ms. A to make an appointment, she showed no resistance at all about coming to see me. I told her that I wanted first to see her, her husband, and her daughter and son-in-law.

When I saw the family together, I acknowledged Ms. A's feelings and thoughts about her mother's death. I underlined the fact that we all had to respect her feelings and thoughts in this regard, the importance of her attending church regularly as instructed by her priest, as well as the need to follow up on the penance he prescribed. In addition, I elaborated on the many cases like Ms. A's among the Cuban community of the United States and told her family how important it was for her grandchildren to understand the sacrifice that Ms. A and her husband had made when they left Cuba thinking primarily about the future of their daughter. Finally, I gave Ms. A an appointment to return to see me, reminding her that I would see her as instructed by her priest. In addition, I strongly recommended that she continue to see her priest as well as me.

Course of Treatment

At the next session, I underlined the fact that Ms. A's mother must have felt very proud of her for her decision to leave Cuba for the benefit of her infant daughter. In addition, I told her that it was very important for her to sleep well so that she could fulfill her housewifely functions, and I prescribed sertraline, 50 mg p.o., at bedtime. I increased her dose to 100 mg 1 week later and to 150 mg 2 weeks later. By focusing on the insomnia and the need to sleep well rather than the depression itself, I was concentrating primarily on a problem that was medical rather than psychological or emotional. This type of approach tends to be better accepted among many Hispanic American patients. Later on during the course of the treatment, when the therapeutic alliance and trust were better established, I focused more directly on the different aspects of her depression. By that time, culturally related resistances did not play a role at all in the

therapeutic process. Ms. A began to improve steadily after taking sertraline for 3 weeks, and her symptoms totally disappeared 3 months after the initiation of the treatment. Seven months later, the medication was progressively decreased and later discontinued. Subsequently, Ms. A was discharged from my care after being free of symptoms for 3 additional months. When the discharge was about to occur, I called her priest, and he was the one who told Ms. A that it was fine at this point to stop coming to see me. Over a year after her treatment with me was discontinued, Ms. A was doing quite well and was completely back to her prior level of functioning.

DISCUSSION

I have presented the case of a Hispanic American woman of Cuban extraction who suffered from a major depressive episode as an illustration of the role of culture on 1) the conception of the etiology of mental illness, 2) the manifestation of depressive symptoms through somatization, 3) treatment compliance, and 4) the need to integrate the medical and psychiatric care with religious institutions in certain ethnic groups.

With respect to the understanding of the etiology of psychiatric illnesses and conditions, it has been well documented in the medical literature that certain ethnic groups related the origin of mental illnesses to spiritual or religious factors (3–5). Psychiatrists must be aware of this possibility and, thus, recognize and respect it during the evaluation and treatment of patients from different ethnic and cultural groups.

In terms of the expression of psychiatric symptoms, psychiatrists must also be aware that Hispanic American patients very frequently manifest their anxiety and symptoms of depression through somatization (1, 2). Therefore, somatic complaints must be understood and integrated as part of these psychiatric conditions, particularly when no objective organic reasons that could explain this type of symptoms are present.

Cultural factors tend to be found often at the core of the problem of treatment compliance (6–8). Therefore, psychiatrists need to understand not only the concept of "disease" as a pathophysiological phenomenon but the concept of "illness" as well, with its host and environment connotations (9, 10). Compliance in the psychiatric

setting depends primarily on the doctor-patient relationship and, above all, on the therapeutic alliance; cultural factors play a unique role in the development of both.

It is not absolutely necessary for the treating psychiatrist to be a member of the culture from which the patient came. The important issue here is for the treating psychiatrist to be knowledgeable about and sensitive to the main aspects of the patient's culture. Actually, in my practice, I have been successful in treating many patients from cultures different from mine by using this treatment approach.

Finally, with certain ethnic groups, religion, as an integral part of their culture, and psychiatry are intrinsically related (11–13). Actually, Hispanics on many occasions consult members of the clergy first about psychiatric disorders or conditions (14, 15).

Obviously, in the discussion of Ms. A's case, it should be noted that dynamic issues—for instance, Ms. A's probable ambivalent feelings toward her mother and her potential unconscious thoughts about the need to take care of a widowed father—were also playing a role. By design, however, I gave priority to the discussion of the cultural aspects of the

case as the main objective for this clinical case conference.

CONCLUSIONS

Undoubtedly, culture plays a major role in physical and mental health care as this case illustrates. Therefore, it is most important that psychiatrists be aware of this fact and incorporate in their clinical armamentaria basic knowledge about their patients' culture. The cultural formulation as described in DSM-IV can be a good beginning in this regard (14).

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