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Inside

Reflections on Teaching Cultural Psychiatry

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Cultural psychiatry is often a neglected topic in medical education, despite the fact that many students do not have the cultural skills necessary to serve today's diverse population. The purpose of this article is to present reflections on lessons learned from a cultural psychiatry curriculum at the University of Wisconsin, Madison.

Why do we bother to teach cultural psychiatry? I have spent the last 2 years working to develop a cultural psychiatry curriculum for third-year medical students at the University of Wisconsin, Madison, and I have asked myself this question numerous times. Sometimes, I believe we teach cultural psychiatry because it is mandatory. The Liaison Committee on Medical Education has several educational standards on teaching cultural competence. The Liaison Committee on Medical Education's educational objectives state that "faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases and treatments," and "medical students must learn to recognize and appropriately address gender and cultural bias in themselves and others, and in the process of health care delivery." Although important, these objectives do not truly answer the question of why we teach cultural psychiatry. A more basic answer is that we teach cultural psychiatry because it is good for patient care and it is good for society.

The mental health system in the United States is predominately directed toward U.S.-born English speaking patients. However, this system is now being forced to serve the mental health needs of patients from multiple cultural, ethnic, linguistic, and socioeconomic backgrounds. Many clinicians are not prepared to serve these populations, and, often, neither residents nor medical students are well-trained in cross-cultural communication skills. The ability to connect with our patients is fundamental in providing good care, and cultural

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skills are critical in determining if we are able to establish a therapeutic bond with our patients.

Despite our growing awareness of the diversity of patients we serve, many minority patients face barriers to accessing quality care. Minority populations often bear the brunt of mental health disparities, with less access to services and poorer quality of mental healthcare when they do access services. Financial, structural, language, literacy, and cultural issues all are barriers to patients entering and remaining in the mental health system. When these barriers are not addressed, society as a whole suffers from an increased burden of untreated mental health diseases.

Although many students and physicians truly desire to reduce healthcare disparities, cultural psychiatry is often a neglected part of psychiatry curricula. At the University of Wisconsin, Madison, our curriculum in cultural psychiatry was an attempt to improve medical student awareness of cultural issues and provide students with the skills in cultural communication that they will need as future medical professionals.

Education in cultural competence is surrounded by many issues, as I discovered through the design and implementation of my curriculum. I interviewed many students prior to starting my curriculum, and several clear themes emerged. First, students often pointed out that when cultural issues are not integrated into the overall curriculum, the legitimacy of cultural psychiatry as a topic is severely reduced. Since cultural competency is already a marginalized subject, adding a single session to the curriculum only further marginalizes cultural issues, encouraging students to think that "this is just the cultural bit; I can ignore this if I want to." Students have commented that "when rotations try to teach culture, they just throw in a lecture somewhere and then never talk about it again."

Students have also struggled with the content of workshops and lectures designed to teach cultural competence. Culturally focused didactics too often consist of lists of ethnic differences that can promote oversimplification and stereotyping. On the other hand, cultural curricula that attempt to explore the broader attitudes and practices of cultural competency are often seen as lacking in content. Students perceive both of these problems quite acutely. For example, one student made the following comment: "I'm sick of all these talks where they tell us 'this is what Hispanic patients think about medical care.' It's just more stereotyping." Another student stated, "I wish it would be less silly and focus more on what I need to know. Tell me how to offer medications to a Hispanic patient!"

In designing my curriculum, I tried to address these issues to the best of my ability. My original goal was to integrate cultural issues into every didactic session the students attended. Our med-III psychiatry clerkship is a 4-week experience, and students attend 4 hours of small group didactics each week. These sessions are primarily case-based discussions and team-based learning sessions. Students are expected to watch an hour-long lecture on the Web prior to attending each small group session. Unfortunately, I was unable to add a cultural component to each didactic and therefore had to find other ways to integrate cultural issues. I decided to do this through a variety of short sessions and diverse teaching media. I meet with students three times over the 4-week block, first to introduce the idea of cultural interviewing and, then, to discuss cases that they have seen. All students are required to assess cultural factors in one patient interview and then write a history and physical or consultation note that incorporates their cultural assessment. This interview, and the reflection paper students write to go along with it, makes up the bulk of the discussion material during our final 1-hour meeting.

In choosing to focus on the experiential learning that occurs while conducting an interview, I had hoped to also address the concern that some cultural workshops are overly stereotyping while others are overly broad and not useful in daily clinical practice. To further reduce this problem, I place specific emphasis on conducting a cultural suicide assessment. All medical students must be competent in suicide assessment, but few assessments address the cultural issues inherent in suicidal ideation and suicide attempts. I have also produced several short videos focusing on culturally based suicide assessment that students can watch if they wish.

At the end of each small group, I conduct a debriefing session with the students to gather their opinions on how cultural psychiatry is being taught. In general, students enjoy their experience and find it valuable. The most frequent comment I receive is that students enjoy the chance to set their own agenda during the cultural interview and interact with their patient in an unscripted way. I do not provide a list of "cultural questions," which most students find to be initially somewhat frustrating, or even frightening, but eventually quite rewarding. Although I often get e-mails from students asking for a "script" to use in their interview, in the end, most feel like the student who stated, "I like that you let us bumble around. You didn't tell us exactly what to ask. We get enough of people telling us what to do." Similarly, during the small group discussions, students often report that they dislike the fact that there are no clear answers to some of the issues raised by their interviews. But they also enjoy being able to debate real-world situations involving cultural issues. One student commented, "At least I'm not watching some guy tell me how important culture is. I can just kind of think about how it really works, which is cool."

In spite of some mixed reactions to the intervention, students in general seem to enjoy exploring cultural issues when allowed to do so in their own way. Although medical students may want a list of risk factors for a myocardial infarction, they do not seem to enjoy lists and explicit instructions when it comes to cultural issues. Allowing students to approach cultural interactions with their patients on their own terms helps demarginalize the traditional position of cultural psychiatry. Engaging students in cultural psychiatry may have more to do with encouraging them to struggle with cultural issues on their own rather than offering more standard lectures or didactics.

Bridging the Gap Between Modern Psychiatry and Cultural Beliefs in the Treatment of Culture-Bound Syndromes

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The term culture-bound syndrome *denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (1, p. 898)*

Vastly diverse, with more than 50 million new immigrants by 2050 as predicted in a 2008 report by the Pew Research Center (2), the United States is an ever growing mixture of people. Concurrent with this population growth is increasing respect for and recognition of the necessity of cultural competence in clinical settings. For instance, 100 Hispanic patients from a primary care clinic in South Texas participated in a survey (3), conducted by the Department of Family and Community Medicine at the University of Texas Health Science Center, which gathered data on five culture-bound syndromes (*nervios, susto, empacho, mal de ojo, and ataques de nervios*). It was found that 77% of the patients in the study had knowledge of all five syndromes, and 42% of patients reported experiencing at least one syndrome. Taking into account both the aforementioned statistic on population growth and the more than 20 culture-bound syndromes described in DSM-IV-TR (1), cultural encounters are likely to become fairly common in medical practice.

Culture-bound syndromes are defined as "specific patterns of aberrant behavior or troubling experiences," (1) whose manifestation and course are recurrent and closely tied to local cultural influences. The term "culture-bound" has not been without controversy as a result of its inherent implication that Western psychiatric classification schemes are universal and applicable across cultures (4). Historically, the integration of Western and non-Western systems of classification of psychiatric illness has been challenged by differences in how illness is both defined and conceptualized (4). These differences in perception often leave Western-trained psychiatrists perplexed when confronted with disorders whose symptoms and presentation do not fit within Western confines.

In some cultures, there are patients who will resort to folk medicine rather than modern psychiatry for a number of reasons (5). Often, it is to avoid a potentially offensive encounter with providers who may be culturally insensitive. Some patients also have little confidence in the effectiveness of modern psychiatry and medicine on what they may consider "spiritual illnesses." Commonly overlooked reasons for reluctance to seek treatment are the social stigma and taboos associated with culture-bound syndromes. This is especially true for patients who must use interpreters and/or may have close ties to their community. Other patients are willing to integrate traditional medicines with modern medicine, and, depending on the cultural context of the physician-patient relationship, these patients may be hesitant to disclose this information to their provider, increasing the risk of adverse drug interactions.

Research in ethnopharmacology suggests that a global overlap may exist between modern psychiatry and cultural beliefs concerning treatment of culture-bound syndromes. An experiment conducted in a collaborative effort by researchers at the University of Ottawa and the Belize Indigenous Training Institute concluded that *Adiantum tetraphyllum*, the four-leaf maidenhair and one of the most commonly used plants in the treatment of *susto* ("fright sickness"), demonstrated evidence of significant anxiety suppression (6). It has been suggested that chamomile, an herb widely used by folk healers, has a suppressive effect on some components of anxiety disorders (7). Although there may be some scientific data that might support the use of folk medicine in the treatment of *susto* and other culture-bound syndromes, the use of traditional remedies is a realm of psychiatry that needs further investigation.

For the practicing psychiatrist, acquiring familiarity with and a knowledge base of the myriad of culture-specific syndromes can seem, at times, daunt-

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ing. Coupled with the fact that many of these syndromes have features consistent with various Western diagnoses, physicians can easily become overwhelmed. It has been suggested that a better concept is to focus less on the specific syndromes and more on the language of illness, the so-called "idiom of distress" (8). Different groups express mental distress in different ways. For instance, there is a greater tendency by non-Western cultures to express mood and anxiety symptoms via somatic complaints (8). Unawareness of the role that culture plays in the presentation of illness can result in improper diagnosis and ineffective treatment. In order for clinicians to better understand a patient's language of illness, there must be first a recognition that a plethora of viewpoints, values, and norms exist both across and within cultures. Second, the physician must be willing to explore and appreciate, in an unbiased fashion, the unique stresses that different groups face. While it is impossible for every clinician to possess a working knowledge of all cultures, it is feasible for clinicians to develop a core base of cultural competence. These qualities produce open, nonjudgmental environments, which promote building trust and good rapport and ultimately result in better patient care and increased compliance.

Dr. Upton is a third-year resident in the Department of Psychiatry and Behavioral Sciences, University of Louisville, and the Editor for this issue.

References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed-Text Revision (DSM-IV-TR). Washington, DC, American Psychiatric Publishing, 2000
2. Passel JS, Cohn D: U.S. Population Projections: 2005-2050. Washington, DC, Pew Research Center, 2008. http://pewhispanic.org/reports/report.php?ReportID=85
3. Bayles BP, Katerndahl DA: Culture-bound syndromes in Hispanic primary care patients. Int J Psychiatr Med 2009; 39:15–31
4. Mezzich JE, Lewis-Fernandez R, Ruiperez MA: The cultural framework of psychiatric disorders, in Psychiatry, 2nd ed. Edited by Tasman K, Kay J, Lieberman J. Chichester, United Kingdom, Wiley and Sons, 2003, pp 648–658
5. Paniagua FA: Assessing and Treating Culturally Diverse Clients: A Practical Guide, 3rd ed. Thousand Oaks, California, Sage Publications, 2005
6. Bourbonnais-Spear N, Awad A, Merali Z, Maquin P, Cal V, Arnason JT: Ethnopharmacological investigation of plants used to treat susto: a folk illness. J Ethnopharmacol 2007; 109:380–387
7. Amsterdam JD, Li Y, Soeller I, Rockwell K, Mao JJ, Shults J: A randomized, double-blind, placebo-controlled trial of oral Matricaria recutita (chamomile) extract therapy for generalized anxiety disorder. J Clin Psychopharmacol 2009; 29:378–382
8. Galanti GA: Caring for Patients from Different Cultures, 4th ed. Philadelphia, University of Pennsylvania Press, 2008

Managing Acute, Dangerous Behavior as an On-Call House Officer

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Aggression, hostility, property destruction, and verbal threats are common behaviors on inpatient psychiatric wards. Psychiatry residents frequently assess and manage patients who display dangerous behavior. The usual goals of management are to maintain patient, staff, and physician safety and to target the behaviors with appropriate interventions. Often, aggressive behaviors are directed toward residents. It may be difficult to meet the aforementioned goals while feeling threatened or frightened. A key component of the psychiatry ward training experience is to develop the confidence and skill set necessary to manage these situations.

Assessment

On-call residents usually hear about acute, dangerous behavior through a page from the nursing staff. The assessment begins by obtaining the appropriate history (i.e., the details surrounding the escalation, the patient's age and diagnosis, whether the patient displayed similar behavior while in-house, the patient's standing medications, whether anyone was harmed, and the patient's vital signs and drug allergies) prior to arriving on the ward. This information often aids in decision making regarding pharmacotherapy as well as security and may allow the physician to order certain interventions prior to arriving on the ward.

After arriving on the ward, it is appropriate to examine the patient and obtain more history from his or her medical chart. Often, residents are unable to fully examine the patient and must observe him or her from a locked nursing unit while intermittently reading the chart. Knowledge of the aforementioned information and several details from the patient's history (i.e., hospital presentation, psychiatric and medical history) assists in quickly thinking through a differential diagnosis of dangerous behavior. Common differential diagnoses of acute, dangerous behavior are psychosis, mania, hostile personality traits, dementia, toxidromes, withdrawal states, delirium, akathisia, and anxiety (1).

Maintaining Safety

The resident must maintain patient, staff, and personal safety when managing these behaviors and may instruct staff members to escort other patients into their rooms in order to decrease their risk of contact with the acutely hostile patient. Security officers usually contain the dangerous patient within a certain area, limiting the patient's contact with staff and peer patients. It is important to maintain a safe distance from the patient and to encourage staff to do so as well. In addition, it is necessary to decide on a final intervention while security officers are present so that they can assist staff if the patient requires placement into a seclusion room or restraints.

Intervention and Outcome

Interventions vary by degree of restriction and the inclusion or exclusion of pharmacotherapy. Some patients respond to less restrictive means, such as redirection (de-escalation). Patients displaying imminent risk of harm to self or others should usually be managed with pharmacotherapy (oral or intramuscular) and possibly seclusion or restraints, depending on the patient's characteristics and frequency of violent/dangerous behavior. It is important to observe and document the intervention's effectiveness and to assess whether the patient requires a more or less restrictive intervention. Certain end points, such as willingness to comply with ward rules and treatment plans, and the absence of objective signs of imminent violence can be used as guidelines for when to reincorporate the patient into the ward milieu.

Reference

1. Petit JR: Handbook of Emergency Psychiatry. Philadelphia, Lippincott Williams and Wilkins, 2003

The Influence of Social Media on Healthcare: Reassessing Confidentiality, Boundaries, and Guidelines

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As a psychiatry resident who has been absorbed by increasing awareness of cultural competence as well as the prospects of healthcare reform, I have often considered how perceptions surrounding these issues are influenced by social media.

The growth of social media has been explosive. Patients, physicians, and healthcare providers in general have utilized these media to communicate, educate, explore, and inform. For example, social media conduits, such as Facebook, Twitter, Linkedln, YouTube, and various blog and virtual communities, can be used to help patients gain access to support networks, reach isolated patients, and provide individuals with opportunities to obtain information outside of the confines of a medical office. In addition, some medical facilities maintain blogs, Facebook and Twitter pages, and a library of YouTube videos as means to foster communication with patients, the medical community, and the general public. However, as healthcare professionals, we are responsible for strict standards of maintenance of patient confidentiality, the validity (i.e., evidence base) of the information we publicize, and maintaining the boundaries of access to our own personal and professional lives. In this era of technology, issues of confidentiality, boundaries, and legitimacy need to be reassessed. Thus, it is necessary that we discuss and establish guidelines concerning our role as physicians in the use of these media and new technology

Please send feedback and/or suggestions regarding prospective guidelines for the role of psychiatry in the use of technology and social media to Dr. Anderson at oanderson@utmem.edu.

My Mental Health Week: Told Via Twitter

MONDAY

VOLUNTEERkidDOC: My weekend is over now and I have pt's to see this week. Only 275 days left (until I graduate).

This will be ADHD week.

No shows all day. School started last week.

One day down. Four more to go.

TUESDAY

OMG. Mom wants disability for six-year old kid with ADHD.

Pt no. 2. Teacher has random scoring. By her account, the kid does not meet criteria for anything.

Pt no 3. Well stable on meds; however, says that he does not want to take meds anymore because he does not want his friends to find out that he is smart.

Pt no 4. Pt not doing well on current regimen.

WEDNESDAY

3 out of 4 have canceled already. Good thing that I overbooked today. 2 out of the 3 overbooks have canceled.

Pt 1. Now 17 and wants to restart meds during standardized testing. Previously took stimulants all throughout elementary school but has skipped the last 5 years. A and B student with and without meds. Now has to take college entrance exams. Mother wants an academic ped.

Pt 2. IQ in the borderline range. School system complaining about hyperactivity and impulsivity. Needs more careful observation

3 more days until the weekend. Must read the Resident Journal.

THURSDAY

Must focus on task at hand.

Focus questions to work on PRITE exams. Question 1.

ADHD group today to assist with executive functioning and social skills. I am the co-host.

Parents focus on the negative and don't emphasize the positive in group today. They need to focus on adaptations to stressors. Kids learn to stop, think, and react.

Focus on the task at hand. It's what I tell each kid everyday.

FRIDAY

The weekend is here.

I have to visit schools today for IEP updates. The treatment team loves it when the physician comes to these meetings. Have to make sure that behavioral modifications give the kid the most positive reinforcement.

Made a left when I should have made a right. Must simplify these directions next time.

Meeting has been scheduled for 2 weeks and the parent did not show up.

I forgot my pen, AGAIN. I don't know where it is. HA!!! I have it attached to my ID badge. [G]rand rounds today.

Book Reviews: *Atmospheric Disturbances* and *The Forgery of Venus*

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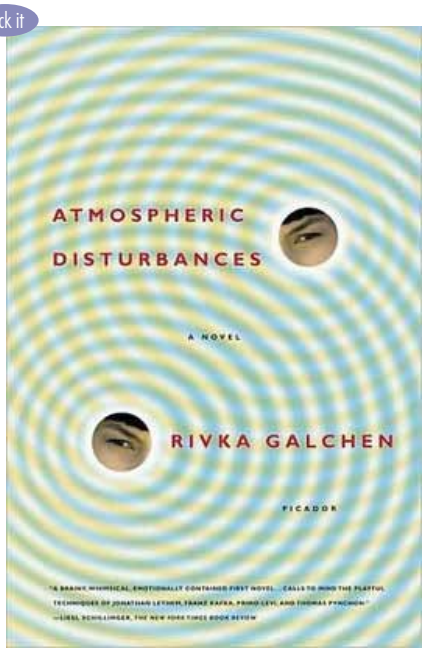
Although some literary references to psychiatry are so badly executed that readers may find themselves cringing with disgust, two recently published novels have folded psychiatry themes into story lines in ways that are both entertaining and fairly accurate. Should you find yourself looking for something in the nontextbook genre to read, *Atmospheric Disturbances,* by Rivka Galchen, and *The Forgery of Venus,* by Michael Gruber, might be appealing.

The protagonist in *Atmospheric Disturbances* is Dr. Leo Liebenstein, a Manhattan psychiatrist. Poor Dr. Liebenstein suffers from Capgras syndrome, manifested, in his case, by the belief that his wife has been replaced by a not-quite-perfect double (or "simulacrum"). While attempting to sort through the distress and confusion that accompany his belief, Dr. Liebenstein also must deal with the fallout of a critical decision the "simulacrum" influenced him to make.

This decision involved his treatment approach with Harvey, a delusional patient who believes he is an agent of the Royal Academy of Meteorology (a highly secretive agency charged with controlling global weather). In an ill-fated attempt at alliance building, Dr. Liebenstein tells Harvey that he is also an agent of the Royal Academy of Meteorology and that he has been tasked with communicating orders to Harvey from the Academy's leadership.

click it



Dr. Liebenstein is funneled toward increasingly bizarre acts meant to keep his lie, and his life, from unraveling. His concretely held belief that his wife has been replaced and the accommodations he must make toward his burgeoning identity as an agent of atmospheric intrigue lead him away from New York to South America. In the cafes of Buenos Aires and the wilds of Patagonia, Dr. Liebenstein is forced to confront doubts about the authenticity of his spouse's identity as well as his own.

Dr. Galchen puts all her credentials (a B.A. from Princeton, with Joyce Carol Oates as a thesis advisor; a M.D. from Mt. Sinai; public health service in South America; and a M.F.A. from Columbia University) to work in making the technical aspects of science and medicine read like poetry. She manages to accomplish this without hitting her readers over the head with the effort. I would venture to guess many of these readers will be looking for a sequel.

In *The Forgery of Venus*, the blurring of reality (similar to *Atmospheric Disturbances)* is a central facet of the story line. The novel's main character, Chaz Wilmot, is a talented but near-destitute painter who takes part in two questionable but well paying ventures in order to provide life saving medical care for his ill son.

The first venture involves participating as a subject in a research study, undertaken by his former roommate at Columbia University. The former roommate is a successful neurologist who is testing a drug called salvinorin.

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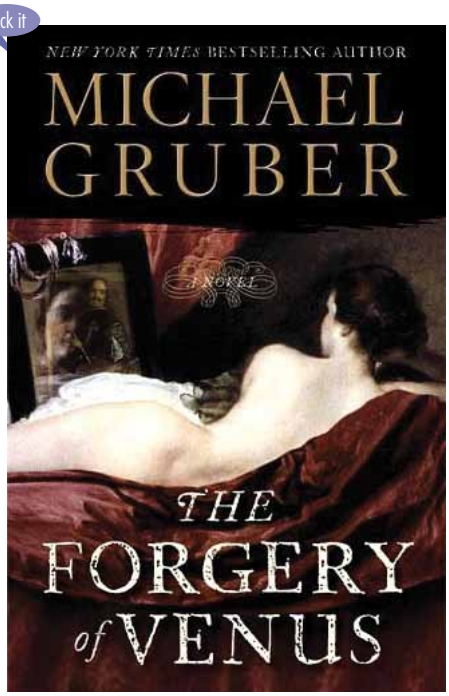

Purported to enhance creativity, the salvinorin experiment yields Wilmot more of a boost than anyone anticipated, as he finds himself imbued with both the talent and memories of the Spanish master Diego Velazquez. This leads Wilmot to his second risky for-profit venture, as he is offered an obscene amount of cash to forge "lost" masterpieces for an underground art dealer.

Both novels make use of an unreliable protagonist who, in the midst of a psychological crisis, is forced to question the reliability of everybody around him and to then make painful compromises that surround the concepts of identity and memory. I recommend these novels as worthwhile and entertaining.

Atmospheric Disturbances, *by Rivka Galchen. New York, Farrar, Straus and Giroux, 2008, 256 pp., $14.00 (paper).*

The Forgery of Venus, *by Michael Gruber. New York, William Morrow, 2008, 336 pp. $24.95.*