MIND AND CULTURE | *Psychiatry's Missing Diagnosis*

Doctors' Approach Might Not Account for Patients' Diversity

PSYCHIATRY, *From A1*

minorities.

It is but one example of a larger pattern: Scientists have broadly played down the role of cultural factors in the diagnosis, treatment and outcome of mental disorders. In part, this is because modern psychiatry is based on the idea that mental illnesses are primarily organic disorders of the brain. This medicalized approach suggests that the symptoms, course and treatment of disorders ought to be the same whether patients are from the Caribbean, Canada or Cambodia.

This model has produced striking successes. Neuroscientists have uncovered key details about how the brain functions and malfunctions, and drug companies have found many effective medications. More patients than ever before have received treatments that have been proven to work.

As the population of the United States grows ever more diverse, however, this approach is facing challenges from within the profession's own ranks. A growing number of advocates for "cultural competence," many of whom are minorities themselves, warn that doctors are harming patients by ignoring evidence about the effects of ethnicity, sex, religious beliefs, social class and national origin on mental health and mental illness.

"The [drug] companies are thinking about the average Caucasian, male patient," said psychiatrist Michael Smith, at UCLA's Research Center on the Psychobiology of Ethnicity, who bemoaned the vacuum of information about drug metabolism and side effects among various groups. Some minorities' distrust of drug trials further compounds the problem, he and other researchers said.

"This thing called psychiatry — it is a European-American invention, and it largely has no respect for nonwhite philosophies of mental health and how people function," agreed Carl Bell, a psychiatrist at the University of Illinois at Chicago.

"A lot of minority groups perceive psychiatric interventions as an ideological approach that discounts their own cultures," added Marcello Maviglia, a psychiatrist who has worked extensively with Native American patients in New Mexico. "A lot of people wouldn't be able to verbalize this, but patients know when you are discounting them, their traditions."

Leaders of mainstream psychiatry vehemently reject this critique. Darrel Regier, director of the division of research for the American Psychiatric Association, said biomedical treatments for mental disorders had been objectively shown to be superior to any other system.

"To say you want to go back to nature and have all the benefits of close-knit families take the place of psychotropic medications — that is wishful thinking and likely dangerous," he said.

Different Viewpoints

Historically, the problem is that psychiatry has been muddled by conflicting theories about the nature of mental illnesses, Regier said. While cultural variations among groups are useful to know about, he added, it is more important for psychiatrists to home in on genetic markers and the brain mechanisms that could be universal to all patients.

"Doctors in general are reductionist," he said. "A patient walks in and you have 10 minutes to find out what in their whole life story is significant. There is a tremendous screening process to cut out irrelevant material."

Columbia University psychiatrist Robert Spitzer, who played a key role in popularizing the medical model of psychiatry, said the cultural advocates are letting politics trump science: "They don't by and large do controlled studies. They mainly complain about the biomedical model."

Spitzer and Regier reflect the eagerness among mainstream psychiatrists to move away from the mushy complexities of culture and the myriad ways in which emotional problems are expressed by different groups, and toward a straightforward system that links groups of symptoms to particular disorders. Ultimately, they hope to find neurological evidence, genetic markers and laboratory tests to differentiate mental problems.

If malfunctioning genes and neurotransmitters can be shown to cause depression, for example, these experts say doctors will be able to treat such problems at their root, making diagnosis and treatment more effective, in the same way that the discovery of the virus that causes AIDS led to highly targeted treatments.

Advocates for cultural competence counter that no matter how much science learns about the brain, culture and the environment will continue to play a huge role in why people develop emotional problems, what treatments they respond to and whether they recover. Doctors, they say, cannot afford to ignore the numerous effects of culture on diagnosis and treatment that have been documented through various streams of evidence and multiple studies in peer-reviewed publications. Among them:

■ Patients with schizophrenia, a disease characterized by hallucinations and disorganized thinking, recover sooner and function better in poor countries with strong extended family ties than in the United States, two long-running studies by the World Health Organization have shown.

■ People of Mexican descent born in the United States have twice the risk of disorders such as depression and anxiety, and four times the risk of drug abuse, compared with recent immigrants from Mexico. This finding is part of a growing body of literature that indicates that the newly arrived are more resilient to mental disorders, and that assimilation is associated with higher rates of psychiatric diagnoses.

■ Black and Hispanic patients are more than three times as likely to be diagnosed with schizophrenia as white patients — even though studies indicate that the rate of the disorder is the same in all groups.

■ White women in the United States are three times as likely to commit suicide as black and Hispanic women — a difference that experts attribute in part to the relative strengths of different social networks.

■ A host of small studies suggests that the effects of psychiatric drugs vary widely across different ethnic groups. There are even differences in the effect with dummy pills.

Keh-Ming Lin, a psychiatrist who formerly headed the UCLA center, said that because psychiatric drugs affect behavior and change how people feel, their effects are powerfully modified by patients' beliefs.

The effects of such drugs "are not solely determined by their pharmacological properties," wrote Lin and colleagues in a book, "Psychopharmacology and Psychobiology of Ethnicity." "The prescription and use of medication is enmeshed in a process replete with social and symbolic meanings and implications."

Cultural Influence

Psychiatric diagnoses are similarly influenced by culture, said Maria Oquendo, a psychiatrist at Columbia University. Women from different cultures, for instance, face very different norms about what constitutes an ideal body weight — and this influences the course of certain disorders: "We consider anorexia nervosa to have biological underpinnings and, therefore, universal, but in less industrialized cultures, anorexia is vanishingly rare. Culture informs our decisions on what we consider normal."

"If we understand that our definition of pathological isn't pathological in other countries, we can make better decisions on when to treat, especially with medications," she added.

Advocates for culture's role in psychiatry describe many case studies to illustrate their argument: Roberto Lewis-Fernandez was a young doctor in training in Massachusetts when he encountered a patient who was 49 and suicidal at Cambridge Hospital. The Puerto Rican woman begged for help in resolving a conflict with her son, but the Harvard University-affiliated psychiatrists focused on one set of symptoms — she was hearing voices, seeing darting shadows and sensing invisible presences.

They diagnosed her as depressed and psychotic, or out of touch with reality, and medicated her. She was discharged. Soon after, the woman had an argument with her son and nearly killed herself by overdosing on the medication.

For Lewis-Fernandez, who is Puerto Rican, the suicide attempt confirmed his fears that his superiors had misjudged the situation. For months, as top psychiatrists ordered him to keep increasing the potency of her drugs, he had told himself that hearing voices, seeing shadows and sensing presences is considered normal in some Latino communities. But he dared not challenge the wisdom of the medical model.

"I wasn't sure if she was psychotic, but I treated her as if she was," he said about the case, which he wrote up in a medical journal. "I gave her the medicines."

When the hospital's outpatient unit evaluated the woman anew, doctors there came up with a different diagnosis. They concluded that her symptoms were not abnormal in the context of her culture — they were expressions of distress, not illness. Lewis-Fernandez helped her reconcile with her son. She still heard voices and saw shadows, but now, as before, they did not bother her.

Unlike anti-psychiatry groups that wish to do away altogether with drugs and doctors, advocates for cultural competence argue only against one-size-fits-all thinking. Genetic vulnerabilities and brain chemistry are undoubtedly important, said Lewis-Fernandez, but his patient was badly served because doctors assumed all her problems could be reduced to brain chemistry.

"Sure, after a certain amount of suffering for a certain amount of time, your brain reacts," he said. "The idea of mainstream psychiatry is that the pill will correct the chemical imbalance in the brain. Yes, but the imbalance keeps happening because of the situation she is in, and the pill can't correct the situation."

Minority patients are not the only ones affected: For one thing, about 40 percent of U.S. doctors training in psychiatry today are foreign-born. "There are so many international psychiatric residents that the real cross-cultural encounters are going to be between foreign physicians and white Americans," Lewis-Fernandez said. "Filipino and Indian doctors [will be] meeting your average Ohioan and saying, 'I don't understand you.' "

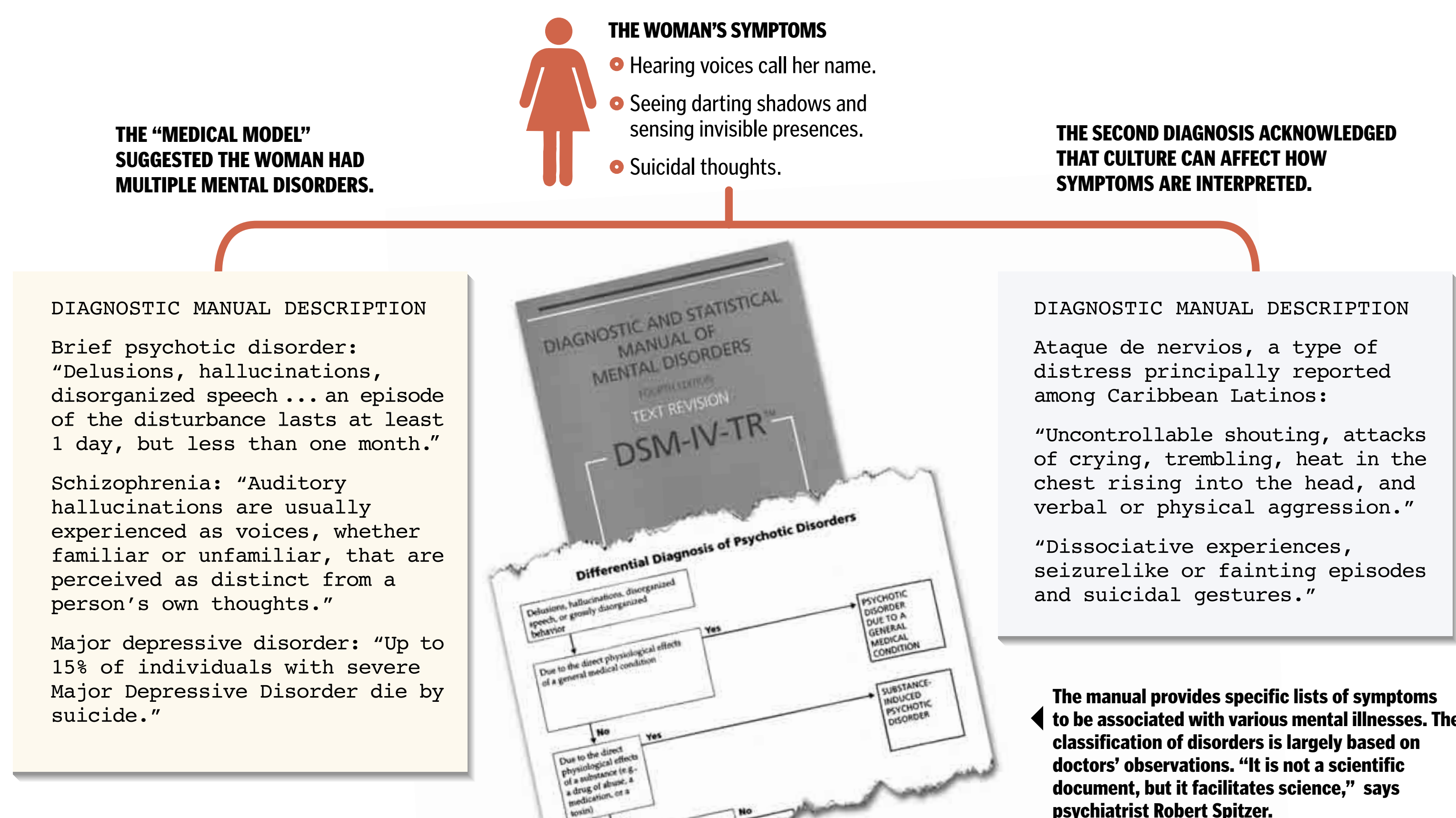
Nor are misunderstandings limited to issues of ethnicity. Differences between clinicians and patients in language, social class or religious belief can also be pitfalls, the advocates warn. Janice Egeland, a behavioral scientist who has worked nearly three decades with the Amish, said she realized something was very wrong when an Amish man went to a friend's house to watch baseball on TV. In the context of Amish culture, which shuns material luxuries and modern technology, his seemingly ordinary action alerted Egeland to a problem that might have been missed by a less experienced clinician. She soon discovered the man had not merely watched the game.

"He was jumping all around, pretending to run the bases," she said. After a thorough evaluation, she realized he was suffering from manic depression, a disorder characterized by alternating bouts of euphoria and depression.

In Illinois, a truck driver was diagnosed as psychotic after he said he frequently saw the devil sitting near him, warning that his life was going to take a turn for the worse. Then a doctor trained to pay attention to cultural issues realized the man was an evangelical Christian whose allegorical religious expression had been misunderstood as a hallucination by secular physicians, said Gary Myers, a clinician at Southern Illinois University in

Disparate Diagnoses

Two groups of doctors produced different diagnoses for a distressed Puerto Rican woman. The first was that she was psychotic and depressed, and she was given medication. The second diagnosis was "ataque de nervios" — expressions of distress that are fairly normal in her culture — and she was provided with family counseling. Both diagnoses are described in the "Diagnostic and Statistical Manual of Mental Disorders," the bible of mental disorders for American psychiatrists.

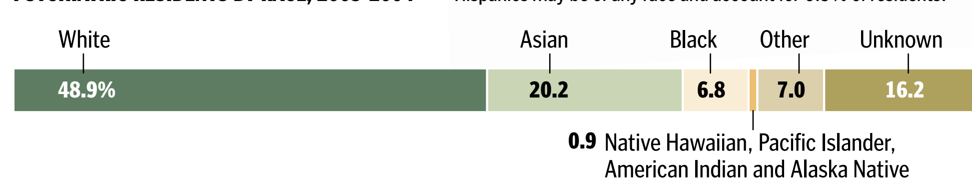


The manual provides specific lists of symptoms to be associated with various mental illnesses. The classification of disorders is largely based on doctors' observations. "It is not a scientific document, but it facilitates science," says psychiatrist Robert Spitzer.

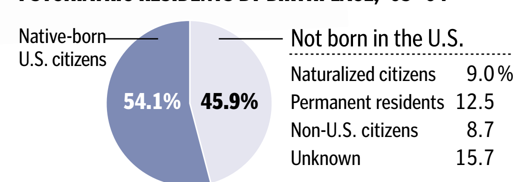
Diversity in the Profession

Many psychiatrists are stressing the importance of cultural understanding in psychiatry. Cross-cultural issues affect white patients as well as minorities: Large numbers of psychiatric residents are foreign born and non-white. Advocates for "cultural competence" say differences in language, social class and religious beliefs can also create misunderstandings between doctors and patients.

PSYCHIATRIC RESIDENTS BY RACE, 2003-2004 Hispanics may be of any race and account for 6.9% of residents.



PSYCHIATRIC RESIDENTS BY BIRTHPLACE, '03-'04



SOURCES: American Psychiatric Association; Diagnostic and Statistical Manual of Mental Disorders; case study presented by Roberto Lewis-Fernandez published in Psychiatric Quarterly

THE WASHINGTON POST

BY JOHN GRESS FOR THE WASHINGTON POST

Psychiatry "is a European-American invention, and it largely has no respect for nonwhite philosophies of mental health and how people function," Carl Bell in Chicago says.

BY MARVIN JOSEPH — THE WASHINGTON POST

At the American Psychiatric Association, from left, Gionne Johnson, Jessica Mikulski, Darrel Regier and William Narrow discuss mental health issues. Biomedical treatment is preferable, Regier says, as it has been objectively shown to be superior to other models and leads to systematic approaches to treatment.

BY HELAYNE SEIDMAN FOR THE WASHINGTON POST

Roberto Lewis-Fernandez says miscommunication is inevitable as growing ranks of foreign-born psychiatrists encounter white America.

About This Series

TODAY

Modern psychiatry asserts that mental illnesses are basically organic disorders of the brain. But a growing number of psychiatrists, many of whom are minorities, say doctors are ignoring the role of ethnicity, sex, nationality and religious beliefs in the origin and outcome of mental disorders.

TOMORROW

A little-known study by the World Health Organization discovered that the outcome of schizophrenia, a deadly mental illness involving hallucinations and disordered thinking, is better in poor countries with limited medical infrastructure than in rich countries such as the United States. Scientists have struggled for decades to explain why.

TUESDAY

Blacks and Hispanics in the United States are far more likely to be diagnosed with serious psychotic disorders than whites. Now, a group of experts who advocate "cultural competence" are asking whether bias may influence psychiatric diagnosis.