



John Furler
Renata Kokanovic

Mental health

Cultural competence

Background

Depression, and its associated anxiety, is very common in the community and frequently managed in general practice. Yet it remains a problematic concept. Differing views of depression influence both clinical practice and research.

Objective

This article discusses the way each patient's culture interacts with other important contexts of clinical practice to shape how depression is understood and managed.

Discussion

Cultural and linguistic diversity interacts with socioeconomic factors in determining the known prevalence of depression and anxiety. Detection of depression may be shaped by expectations and assumptions of both the general practitioner and patient. Language and communication barriers mean interpreters are critical to mental health care. Culturally sensitive care for depression requires a reflective approach based on a negotiated understanding of the patient's experiences and symptoms.

Keywords: cultural competency; doctor-patient relations; mental health; depression



Depression, and its associated anxiety, is very common in the community and frequently managed in general practice. Yet it remains a problematic concept. Contrasting views of depression influence both clinical practice and research. In one perspective, depression is an identifiable disease with clear diagnostic criteria, independent of time, place and culture.¹⁻³ Another view sees depression primarily as a socially constructed phenomenon, closely dependent upon time, place and culture.⁴ Although polar, these views are not mutually exclusive. Both views are implicated in the work of general practitioners in 'producing' depression, whether through extending the reach of diagnosis and therapy or through medicalising individual troubles and worries. This may be driven by a range of interests, including pharmaceutical companies and the medical profession, but also the needs and expectations of patients and communities.⁵

This article draws on both these perspectives as primary care of depression negotiates a path through these differing views. The unique nature of clinical care for depression in general practice is acknowledged in the *beyondblue* publication, *Guide to the management of depression in primary care*.⁶ In this context, depression 'survives' as a diagnostic category and workable concept⁷ serving a purpose in framing our responses to the presentation of patients with distress. The following discussion outlines how 'culture' is an important factor in depression care in general practice. Understanding how culture is influential can help us provide the best possible care for depression as well as ensure we reflect critically on our role in depression 'production'.

Depression prevalence

Putting aside conceptual difficulties in understanding depression, identifying the underlying prevalence of mental illness in culturally and linguistically diverse (CALD) communities is complex. Numerous factors influence the reported prevalence of these conditions and clinical practice. These include:

- socioeconomic context
- linguistic diversity
- individual history of trauma, and
- expectations of both the patient and the health professional.

The 2007 National Mental Health Survey⁸ suggested that nearly



half of the community report a lifetime history of some type of mental disorder and that 20% have had symptoms of a mental disorder in the past 12 months. This primarily refers to the high prevalence conditions anxiety and depression and related disorders. Significantly higher rates of mental health problems are reported by people from socioeconomically disadvantaged backgrounds, while lower rates are reported by people born overseas. However, there is enormous diversity within overseas born Australians.

Socioeconomic and cultural factors

Cultural and linguistic background and socioeconomic factors interact in complex ways that influence health and wellbeing. While over one-third of the community identify as having CALD backgrounds,⁹ these communities come from a range of social, educational and economic backgrounds. Each carries associated risk or protective effects in relation to health and mental illness. For example, unemployment and lower incomes are more common in recent arrivals, older migrants, those with minimal English language proficiency, and those with unskilled backgrounds.¹⁰ This in itself is associated with higher rates of mental illness. Refugees are particularly vulnerable, with personal narratives of trauma and loss. The work of GPs is particularly complex at the interface between concepts of depression and symptoms related to torture, trauma and stress. This complex diversity poses a challenge for the delivery of equitable, high quality primary care, particularly in mental health.

Depression in the general practice setting

Working across cultural difference is now a daily experience for many GPs and other primary health care professionals. At a practice level, culture and ethnicity influence the identification of depression and anxiety. Overall GPs manage mental health problems at a rate of 10.8 per 100 encounters. Depression is the most commonly managed mental health problem (35% of all mental health problems managed and 2.6% of all managed problems). Anxiety is the next most commonly managed mental health problem (15% of all mental health problems managed).¹¹ However, depression may be under recognised and under treated among ethnic minority groups.¹² Comino et al¹³ showed substantial under detection of symptoms of depression and anxiety among Asian patients presenting to GPs, even when those patients self identified those symptoms. It is unclear whether this reflects underlying differences in the prevalence of mental illness, differences in the way patients present (or don't present) or differences in the clinical behaviour of GPs with patients from differing ethnic backgrounds.

Culture and depression

Cultural factors influence the illness experience in a number of ways; defining experiences or sensations as either 'normal' or 'abnormal' and shaping beliefs about the causation of illness. This in turn can determine whether, when and how people seek medical help for mental illness, and their expectations. For example, somatic presentation of symptoms may be more common in some cultures.

In the authors' study of depression in ethnic minority refugee communities in Melbourne (Victoria) and Tasmania,^{14,15} patients reported a wide range of somatic symptoms in stories of how they engaged with their GP. The stigma associated with mental illness may be one reason for this.

However, there is a danger in seeing culture as a fixed, 'essentialist' idea where we can rely too heavily on it to explain and understand identity. Culture is best understood as a dynamic 'ever changing construction that emerges from interactions between individuals, communities and larger ideologies and institutional practices'.¹⁶ It means more than simply ethnicity or language group, referring to the interaction between the broader social and societal factors underlying health experiences. Culture is an interactive and continually evolving aspect of identity and experience. From a general practice perspective it is one of many factors that can influence the recognition and detection of mental illness as well as ongoing care.

The importance of communication

Communication is particularly important in depression and mental health care. Bilingual GPs play an important role in detecting, diagnosing and managing mental health problems for members of ethnic minority communities, as well as in offering family support and mental health promotion.¹⁷ However, the majority of patients from non-English speaking backgrounds consult GPs who work primarily in English.¹⁸

Klimidis et al¹⁹ surveyed GPs providing mental health care to patients from ethnic minority communities. The most common barriers GPs reported were language and communication barriers such as poor access to bilingual allied health services and lack of translated patient educational materials. The GPs associated this with low patient compliance with treatment. Interpreters are important in overcoming language differences, although this adds complexity to the interaction. The authors' study identified that interpreters do not act as simple conduits of words but play an important and active role in shaping the encounter between GP and patient in clinical care for depression.¹⁴ Empathy, trust, rapport and body language were all important in developing a three-way relationship between patient, GP and interpreter.

Beyond language, different values, beliefs and preferences can have an important effect on the course of depression care, shaping the patient-doctor relationship.²⁰⁻²² In Comino's study¹³ ethnicity influenced the outcomes of care, with Asian patients being less likely to be referred for secondary care. Again, this may be shaped by the GPs own assumptions and beliefs. They suggested, for example, a need to 'overcome the stereotype that patients from Asian cultures are inhibited about discussing their emotional problems'.

Working across culture can highlight our own cultural 'baggage', based on our personal backgrounds, and the medical world we inhabit. Health professionals have their own 'culture' shaping their expectations of patient encounters, defining what is an appropriate patient-doctor relationship and how clinical decisions should be made and management plans implemented.²³ General practitioners may



'adapt' their communication and information sharing with a patient according to their perception of the patient's culture, hoping to improve compliance. However, this may reflect assumptions and frameworks that we bring to caring for patients. Reflecting on our role in this may challenge the very concepts of depression and anxiety and how we understand them in our work.

The importance of the GP's own culture and the need to reflect on the role it plays in clinical care is captured by the model of 'negotiated understanding' by the Victorian Transcultural Psychiatry Unit (Figure 1).²⁴

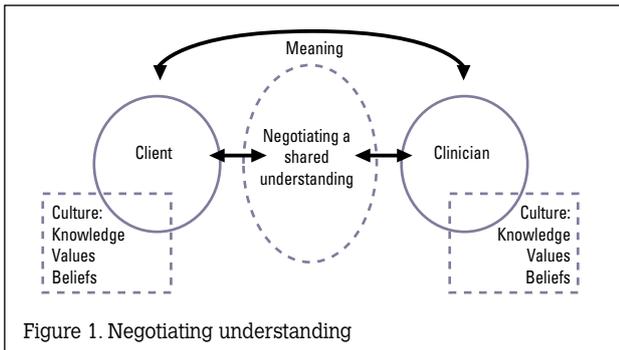


Figure 1. Negotiating understanding

Conclusion

Culture and ethnicity interact with a range of other social and economic factors in profoundly shaping clinical practice for depression and anxiety. Many questions remain unanswered. General practice has an important role to play in ensuring equity of access to mental health services for CALD patients and ensuring that the services we provide are culturally sensitive and appropriate. What is required is not guidelines detailing the relationship between depression, culture and ethnicity, or a checklist strategy, but rather a reflective approach that avoids stereotypes and assumptions in providing care that is culturally sensitive and aware.

Authors

John Furler MBBS, FRACGP, GradDipPubHlth, PhD, is Senior Research Fellow, Primary Care Research Unit, Department of General Practice, The University of Melbourne, Victoria. j.furler@unimelb.edu.au

Renata Kokanovic BA(Hons), PhD, is Monash Fellow, Department of Sociology, School of Political and Social Inquiry, Monash University, Victoria.

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correspondence afp@racgp.org.au