Managing mental illness in patients from CALD backgrounds

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BACKGROUND

Australian general practitioners are often the first point of call for people seeking mental health care including those from culturally and linguistically diverse (CALD) backgrounds, some of whom may be more at risk of having a mental illness but are failing to access the appropriate mental health care.

OBJECTIVE

This article is intended to assist GPs in the recognition, diagnosis and management of mental illness in patients from CALD backgrounds by providing current research evidence and presenting some practical recommendations. More attention is paid to the larger CALD populations such as the southern European and Asian communities, and does not deal with indigenous Australians.

DISCUSSION

There is an increasing call for GPs to have a key role in the detection, diagnosis and management of mental illness, including for patients from CALD backgrounds. Effective care requires that GPs are aware of, and understand how culture may influence recognition, diagnosis and management of mental illness in this group of patients.

A significant proportion of Australia's population consists of people from culturally and linguistically diverse (CALD) backgrounds. According to the Australian 2001 Census, 28% of the Australian population were born overseas; 15% in a non-English speaking country (*Table 1*).[1] Notably, older persons from CALD are becoming a substantial subgroup among the Australian population; by 2026 it is projected that one in four people aged 70 years and over will be from a CALD background.[2] These figures will have significant implications for general practice as general practitioners are often the first point of contact for people requiring mental health care. However, even though census data has indicated that 15% of the Australian population is from a CALD background, only 7% of encounters with GPs were recorded for CALD people in a national survey of GP-patient encounters.[3] These consultations were less likely to involve a psychological or social problem than patients from an English speaking background.[3] Research also suggests that people from CALD backgrounds often prefer to consult with GPs who are of the same ethnic background or who speak the same primary language as themselves.[4]

Research regarding differences in rates of mental illness in CALD populations compared with their Australian born counterparts has been equivocal. The National Health and Wellbeing Survey found little difference in rates of affective and anxiety disorders between people from CALD backgrounds and Anglo-Australians[5] (although the study excluded those who could not speak English sufficiently well to complete the interviews). However, more recent Australian studies employing culturally sensitive research methodology (ie. interview in participant's own language) have shown that people from CALD backgrounds have higher levels of depression and anxiety than their Anglo-Australian counterparts.[4,6] The discrepancy between the low level of GP consultations involving social and psychological problems found in CALD populations, and higher rates of mental illness noted in some

CALD populations, have been attributed to a number of factors related to the presentation of illness by the patient and the underdetection, misdiagnosis and management of mental illness by GPs.

What is culture?

Culture has been defined as a shared learned behavior transmitted from one generation to another for purposes of individual and societal growth, adjustment and adaptation.[7] It is represented externally as artefacts, roles, and institutions, and internally as values, beliefs, attitudes and biological functioning.[7] The term 'culture' also refers to the shared heritage and social distinctiveness of the multiplicity of the ethnic components within a community. However, it is important to note that it is impossible to generalise characteristics of a particular culture to all members of that group, as not all members subscribe to the values, beliefs or behaviours common to that group and members have different levels of acculturation to mainstream culture.[8]

Presentation, detection and diagnosis of mental illness

The influence of culture

Mental illness in different cultures constitutes different forms of 'social reality'[9] and needs to be understood within the cultural context. Cultural factors shape mental illness including how it is understood and explained, its experience and manifestation, and its course and epidemiology.[10,11] Some factors influenced by culture affecting the GP-patient interaction include: somatisation, explanatory models, perception of the GP by the patient, the patient's social context, stigma associated with mental illness, language difficulties, the GP setting, the role of family and other social networks and expectations of medication and religious beliefs.

Somatisation

Cultural variations have been noted in the expression and presentation of mental illness in general practice.[12] Patients from some CALD backgrounds who have a mental illness may present more often to their GP with somatic rather than psychological symptoms.[13–15] This has been termed 'somatisation' and can be understood as a culturally appropriate way of expressing discomfort in many cultures.[13,16,17] For example, CALD patients might complain to a GP of somatic symptoms such as insomnia, headaches, lethargy, abdominal, muscular, back and joint pains, rather than low mood or negative thoughts.[15,18]

Explanatory models

Detection of mental illness in general practice can be influenced by the patient's conceptualisation of the illness experience or their 'explanatory model'.[19] An explanatory model relates to the meaning of illness, specifically, what constitutes the views of causes, important symptoms, course, consequences, and treatments or remedies.[20] All aspects of the explanatory model are influenced and shaped by culture and social factors such as socioeconomic status and education,[21] and can influence help seeking, compliance with treatment and patient satisfaction.[22]

Cultural variation in explanatory models is particularly relevant to causal attributions of mental illness. For example, psychosomatic causation is widely accepted by southern Europeans for anxiety or depression.[23] Indeed, in much of Italian and Greek culture 'nerves' or 'nervous breakdowns' are not highly stigmatised but are viewed instead as common, often minor, afflictions.[23] The typical treatment of 'nerves' may include prayer, efforts to adopt a better attitude or seek a change in the social or physical environment.[23] Additionally, causal beliefs about mental illness in older people of southern European cultures have included witchcraft, demonic forces and supernatural explanations, especially in females of low socioeconomic status and low educational levels, and those that migrated from rural areas.[24] Therefore, GP consultations with patients from CALD backgrounds may require a 'negotiation of explanatory models' where differences in belief systems are acknowledged and respected. Questions around the patient's view of mental illness will elicit information about their explanatory model. *Table 2* provides questions that can be used by GPs to elicit CALD patients' explanatory models based on Kleinman's[20] original concepts of health and sickness and the Short Explanatory Model Interview (SEMI).[25]

Table 1. Australian 2001 census data: birthplace by country for NESB*

Country	% NESB population
Italy	1.15
Vietnam	0.82
China	0.70
Greece	0.61
Germany	0.57
Philippines	0.55
India	0.50
Netherlands	0.44
Malaysia	0.41
Lebanon	0.38
Poland	0.30
Yugoslavia	0.29
Sri Lanka	0.28
Croatia	0.27
Indonesia	0.25
Malta	0.24
Fiji	0.23
FYROM**	0.23
Republic of South Korea	0.20
Singapore	0.18
Egypt	0.17
Turkey	0.16
France	0.09
Born elsewhere overseas***	3.70

* non-English speaking background
** Former Yugoslav Republic of Macedonia
*** born elsewhere overseas (includes inadequately described, at sea, not elsewhere classified)

Perception of the GP

Patients from CALD backgrounds may have different expectations, concerns, meanings and values about GPs, and may view the GP as the expert on physical illness. They may think their role as patient is to present and describe their physical illness; in part this may explain the high rate of somatic presentations to GPs.

It may also explain why emotional, social and psychological difficulties are less often reported to a GP, as the problem may not be considered relevant or appropriate to report to a GP.[20,26]

Some studies suggest that different communication styles in patients from CALD backgrounds may be characterised by a less direct and assertive manner.[27] This may explain why patients sometimes readily agree with the treatment plan (in order to please the physician) but do not comply. Other studies suggest that patients from CALD backgrounds may expect a more authoritarian GP in the patient-doctor relationship, often resulting in passive acceptance of treatment and low demand for education about medication.[28]

Patient's social context

Mental illness may be strongly influenced by adverse social circumstances and may alert the GP to the possibility of a mental illness.[29,30] For example, factors affecting the clinical presentation may include the political context of arrival, reasons for migration (eg. refugee, economic), level of contact with the Australian majority group, level of exposure to high risk industries, and lower postmigration employment status relative to education. Recent adverse life events (>1 in the past year) could be seen as a reliable indicator of mental illness in CALD patients, in addition to multiple visits to the GP (>10 visits per year). Therefore, those patients from CALD backgrounds who have had recent adverse life events or who attend the GP frequently, warrant particular attention regarding their psychological wellbeing.

Patients from CALD backgrounds are also more likely to present to the GP at a later stage of their mental illness, tolerating a great deal of emotional and psychological distress before seeking professional assistance.[13] Patients may consult a GP after having consulted a number of other culturally appropriate 'healers', or may be using other culturally sanctioned remedies and rituals for their mental health.[13]

Table 2. Eliciting explanatory models of illness in CALD patients

Nature and causes of the problem
When did you first notice that there was a problem?
Why do you think that the problem began when it did?
What do you call this problem? What is its name?
How long ago did you first notice these problems?
What do you think caused this problem?
Do you think that this problem is an illness?

Important symptoms of the problem
What do you think are the most troublesome aspects of this problem?
Which symptoms trouble you most?

Development and course of problem
How did the problem develop with time up to now?
How do you think this problem may develop and progress over time in the future?
Do you think the condition would become worse, improve or stay the same, or come and go over time?

Severity and consequences of the problem
How serious do you think this problem is?
What are the most and least troublesome aspects of the problem?
What are the main difficulties your problem has caused you? How does the problem affect your relationships, work/study, family role and responsibilities, attending to your daily needs?

Treatment and help seeking for problem
Is there a particular way that people in your culture/ethnic group deal with this type of problem? What is usually done?
Is this relevant to do in your case?
What do you think will be effective to help with this problem in your case?
What do you think you can do to help with this problem?
How do you think I can help with this problem?
(If medicine is asked for) Do you think the medicine will cure the problem or just help control it? How quickly do you expect the medicine to do this?

Stigma

The stigma associated with having a mental illness may be particularly strong in some CALD populations and this affects symptom disclosure and help seeking behaviour. This may be one of the explanations for presentation with somatic symptoms as these may be viewed as more socially benign than a psychological problem.[31,32] Depressive symptoms may be seen as socially disadvantageous, and in some cultures may interfere with marriage prospects, diminish social status, and compromise the self esteem required to perform effectively in society.[31,32]

Language difficulties

Language preferences affect selection of GPs by people from CALD backgrounds – with recent surveys showing that 39.5% of non-English speaking patient consultations were where the GP consulted in a language other than English,[3] and 78% of CALD patients with poor English proficiency attended bilingual GPs.[4] For nonbilingual GPs, a trained interpreter should be used to ensure a meaning orientated translation. Interpreters are available through the Translating and Interpreting Service (www.immi.gov.au/tis/) or

VITS (www.vits.com.au/services/interpreting.htm). Using an interpreter will help avoid mistranslations of biomedical concepts and errors of omission. An interpreter is preferred over a family member as the patient may not want to disclose information in front of family and/or the family member may add their own interpretations.

General practice setting

Underdetection of mental illness in general practice is a complex issue that may be exacerbated by difficulties in eliciting a psychiatric history from CALD patients.[33] For example, GPs have been shown to diagnose CALD patients using more limited indicators of depression (ie. depressed appearance, sleep disturbance, weight and appetite changes) and are more likely to detect more severe mental illness in general practice.[33] Therefore GPs need to be alert to the early signs of emotional difficulties in CALD patients.

Role of family and friends

In many cultures, family members and close friends play a key role in the patient's health care and often accompany the patient, especially if they have limited English skills. The GP needs to make sure that the patient has explicitly given permission for any discussions that might violate the patient's confidentiality. Where strong collectivistic values typify the culture, the GP should be aware that they may be negotiating treatment with the entire family even if they are not present. Acknowledging the importance of other family members and accommodating their views of the treatment is often essential to adherence to the treatment plan.

Pharmacological management

Noncompliance with psychotropic medications appears to be more problematic and prevalent in some nonwestern cultures.[34] In recent years, research has found significant differences among ethnic groups in their response and propensity to side effects of medications related to genotypic variations in drug metabolising isoenzymes.[35–37] These differences lead to variability in pharmacokinetics (ie. absorption, distribution, metabolism and excretion) and pharmacodynamics (ie. drug response to psychotropic agents).[38] Metabolism is regarded as the most significant factor in determining inter-individual and inter-ethnic differences.[39,40] While a detailed description of these differences is beyond the scope of this article, GPs should consider variable metabolism between ethnic groups before prescribing psychotropics such as antidepressants, benzodiazepines or antipsychotic medications.

Expectations of medications

Expectations of drug effects are strongly influenced by a patient's cultural origin. For example, in some studies, patients from a CALD background are more likely to have negative attitudes toward medications and to have poorer medication adherence.[34] In some studies, Chinese patients commonly perceived that western medicines were more potent and had greater adverse side effects than herbal or traditional therapies.[41] In another study examining the side effects of lithium in Chinese patients, although the actual side effect profile was similar to caucasians, Chinese patients showed more concern about fatigue and drowsiness and were less concerned about polydipsia and polyuria as such side effects were regarded as a way of removing toxins from the body.[28] A further study found that even though Chinese patients expected western medicines to act quickly, they did not expect them to treat the underlying condition.[42]

Religious beliefs

Religious beliefs may also affect compliance with medication in people from CALD backgrounds. For example, changes in intake time and dosing of medication by some Muslim patients during Ramadan have been found, often without seeking GP advice.[43] As efficacy and toxicity of psychotropic medications can vary depending on the time of administration and their interaction with food intake, GPs must consider religious beliefs when advising patients. This is even more relevant for drugs with a narrow therapeutic index as the risk of toxicity or side effects are higher.[43]

Referral

General practitioners are the most common referral source to specialist mental health services for people experiencing a mental illness and studies suggest that people from CALD backgrounds are accessing specialist mental health services at a lower rate compared to the Australian born population.[4] General practitioners should familiarise themselves with bilingual mental health professionals and ethno-specific services where they can refer CALD patients or receive specific advice regarding assessment and treatment.

Conclusion

General practitioners play a key role in the detection, diagnosis and management of CALD patients with mental illness, although more research is clearly needed. Effective care requires understanding and awareness of how culture may affect the patient, GP, and setting factors. The complex task of managing mental illness in CALD populations can be made easier by better understanding of the patient's culture, social and family context, their explanatory models, their perception of the GP, and the stigma associated with mental illness. Additionally, GPs need to be aware of factors contributing to the variable metabolism of medications across CALD groups.

Summary of important points

- Negotiate explanatory models with your patient.
- Be aware of the stigma that mental illness may carry in some cultures.
- Use interpreters to facilitate the GP-patient interaction.
- Involvement of family and friends may facilitate the GP-patient consultation and treatment compliance.
- Pharmacological effects may differ in patients from CALD backgrounds.

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