Synthesis of Psychiatric Practice - East and West meet

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Introduction

Definition of culture is difficult. Nevertheless, culture controls our lives (Pedersen & Ivey, 1993). Cross-cultural psychiatry classically deals with the interaction between culture and the experience and expression of psychopathology. It discusses the role of culture in the course and outcome of psychiatric disorders. The concepts of culture-bound and culture-free syndromes are common knowledge now. Cross-cultural themes also cover explanatory models of illness and traditional models of treatment followed in different cultures.

The society is becoming more diverse with the evolution of a “global village” environment. The geographical boundaries that defined cultures have become porous. Multiethnic and multicultural societies are becoming commonplace. A psychiatrist from India caring for a patient of Greek origin living in Australia does not raise any eyebrow nowadays. For the purpose of this article, I thought it would be interesting to look at issues that may arise in such a multicultural scenario. I grouped cultures as the East and the West (euphemism for developing and developed societies respectively). This division may not be very valid but people from these two societies do differ significantly in many facets of their life. Economy, politics, religion, language and communication, belief systems, family norms and lifestyle are some of them.

East and West Meet

There is an increasing level of interaction between practitioners of psychiatry and patients from these two different cultures. Each comes with their unique understanding and models of mental health care. On this background, a new issue for cross-cultural psychiatry is emerging synthesis of cultures in the treatment setting. Gaw (2001) raised the question “Can diagnosis and treatment be provided that will be perceived as relevant and acceptable by patients coming from (cultural) backgrounds different from those of the clinicians?” The focus in psychiatric practice has widened from clinical competence to cultural competence. The ingredients of this cultural competence include knowledge and sensitivity to characters of a culture, ability to empathise and adjust with the culture and making a choice of culturally suitable treatments that work best for patients (Tseng, 2003). Cultural competence is required to avoid the experience and knowledge of psychiatric practice in one culture becoming irrelevant and counter-therapeutic in the other.

I will refer to India as a model for the East and Australia for the West. My thoughts have emerged from experience in psychiatric practice for two decades in India followed by work for the last two years in Australia. There are a number of issues that come to mind that pose potential conflict of cultures when people from these two countries meet in a treatment setting. I have discussed here only some of them. The themes are not new to professionals but their content and import varies in the two societies and all may not agree with what I have said. I endeavoured not to project a false impression that psychiatric practice in one culture as always better than in the other.

Issues of synthesis

The safety of the patient takes priority in any medical intervention, more so in psychiatry where the patient is at increased risk of harm to self and sometimes to others. In Australia, the safety issue is not restricted to the patient but also the professionals working with them. This is due to a heightened risk of perceived and real harm to them from patients. This position contrasts with the usual experience in India. Professionals from the West visiting India have expressed surprise at the degree of safety the patients, families and the professionals feel with each other in their daily interactions. A psychiatrist from India is often surprised by the contrary position in the West. It is not a good idea for the clinician to apply feelings of safety or risk he or she had back home in the other culture.

The frequency of use of high-dosage of drugs regimes is much higher in Australia than India. For example the maximum dose of clozapine used for chronic treatment resistant schizophrenia at a specialised centre in India is around 400 mg per day compared to 1000mg or more used in a similar setting in Australia. The factors that determine use of such high dose regimes in Australia are many. Increased body mass due to highly prevalent obesity in the general population, high prevalence of substance use and...
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smoking by psychiatric patients, the need for a vigorous regimen arising from concern for risk to harm and relapse as many patients do not live in a formally supportive environment like the family, medication non-adherence, and lastly, but not the least, a fundamental pharmacokinetic and pharmacodynamic differences between Indians and Australians could be some of them. This is a very interesting area for cross-cultural social and biological research.

A medication related issue is treatment adherence. Non-adherence to medication is a common phenomenon in psychiatric patients. In India, doctors can often ensure adherence merely by the role position they hold with respect to the patient. The family in India has the major role in managing non-adherence and minimising the need to hospitalise the patient (Srinivasan & Thara, 2002). Patients live independently in Australia more often than in India. Hospitalisation and legally mandated community treatment orders under the Mental Health Act are frequently used for the Australian patient. Even when the family is available, it may not be able to influence the patient as much as it does in India.

The doctor in Indian practice is generally taken as the final judge of treatment plan for the patient and the family. The professional decision is not often questioned even if the patient or family differ in their opinion. This is not necessarily because of low literacy or ignorance of the consumer but probably to acceptance of the higher position of the doctor in the social role hierarchy. In Australia, the psychiatrist is still the final decision maker but significance is placed on the preferences and wishes of the patient, even when acutely ill. The doctor needs to discuss clearly issue of treatment like the rationale of treatment, the outcome expected and the side effects before arriving at a decision. This need for informed decision mitigates, to some extent, the problem of the frequent medical malpractice litigations in Australia. Either practice has some advantages and disadvantages, to the patient and the doctor. It is the use of one in the other that is inappropriate and may be harmful.

The psychiatrist is usually the uncontested leader of a mental health team in India. A clinician coming from India with such an experience may often find that this position in a team is not so clear-cut in Australia. The opinion and suggestions from all the members of the team is given equal importance in making a decision. One needs to understand the work culture and people’s attitudes and practice of their rights and responsibilities in Australia that may be at variance with what one sees in India. This hierarchy or the relative lack of it has deeper roots in the respective culture. It is also reflected in the way the social positions and roles of people are determined in the family, workplace and the community.

The welfare of a patient involves provision of the basic needs of shelter, food and clothing, safety and access to health care and social benefits. All these measures work towards an enhanced quality of life for the patient and reduce their alienation from the society. In India, the family takes the primary and often the sole responsibility for many of these tasks. But for the enormous burden borne by the Indian family system, it would be impossible for the existing health care and welfare system to care for the millions of patients in the country. In Australia, the family still plays a significant role in the care and welfare of a number of patients, especially in the rural and remote areas where health and welfare facilities are difficult to access. The State plays a much larger role in providing welfare measures to the disadvantaged citizens in Australia than in India. One may get the impression that the Indian state does not care and the Australian one cares too much. In the final count, the difference between the two societies is in who cares. Treatment plans in either culture have to take this into account.

Conclusion

Multi-cultural psychiatric teams and patient populations are becoming increasingly common in the world. The process of acculturation in such settings is multi-dimensional. Firstly, the doctor from one culture has to relate to doctor from another. Secondly, he or she has to adapt to the cultural background of the patient and lastly, often forgotten, the patient has to grapple with the cultural style of the doctor. Programs orienting the practitioners to each other’s culture would foster the development of an effective team and optimal utilization of the cultural assets of its members. Forums where the patients and their families can discuss and sort out issues they face with multi-cultural treatment teams are essential to make an effective cultural synthesis of psychiatric practice. Resolution of cultural conflicts and adoption of positive ingredients from different cultures would pave a way to provide quality care to patients.

References

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