Cultural Awareness Tool

UNDERSTANDING CULTURAL DIVERSITY IN MENTAL HEALTH

CONTENTS

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FOREWORD

In addressing the problems faced by people from Culturally and Linguistically Diverse (CALD) backgrounds, health service providers are encouraged to have a 'culturally-appropriate' or 'culturally-sensitive' approach to the assessment, diagnosis and management of clients. However, despite this imperative, strategies directed at altering the practices of the service providers in an enduring manner have largely been ineffective.

To facilitate improvement in the quality of care of service providers, development of the Cultural Awareness Tool (CAT) was conceptualised. This tool, derived from the successful 'Checklists for Cultural Assessment', produced by the Queensland Health Department, is aimed at providing practitioners with general guidance in how to manage clients with mental illness in a more culturally-aware manner. In its entirety, the tool would guide practitioners in eliciting their CALD client's understanding of the presenting problem, whilst conducting such an investigation in a culturally-sensitive manner.

Following a comprehensive consultation phase, this tool was piloted among a diverse range of health and mental health practitioners. It is therefore designed for use by a variety of clinicians including Psychiatrists, Clinical Psychologists, General Practitioners, Social Workers, Mental Health Nurses and Occupational Therapists. We acknowledge that practitioners may themselves be from CALD backgrounds, but hope that the material is still useful in providing a general understanding of the influences of culture.

ABOUT THE TOOL

The tool consists of a small booklet and accompanying hand-held card. Although it does not attempt to provide comprehensive information on all aspects of culturally sensitive care, it is designed as a first step in developing cultural competence. Based on usage of this tool, our hope is that health and mental health practitioners will further develop their own knowledge concerning culturally-sensitive care.

The 'pocket-size' card contains questions designed to elicit the client's explanatory model of their illness and medical encounter, and how the patient's cultural background affects their health beliefs and behaviours. Background information regarding the rationale for using the card is provided in the booklet.

A case study illustrates the ways in which culture affects all aspects of mental illness and care. A number of general points about issues that may be relevant for clients from CALD backgrounds are highlighted.

The booklet also includes general information on how to interact with a client from a different ethnic background, including the use of interpreters. These sections also provide information on the Translating and Interpreting Service.

While it does stand alone, this tool may be used in conjunction with the culture-specific information available in the Culture and Health Care file developed by the Multicultural Access Unit of the Health Department of Western Australia (orders can be placed on (08) 9400 9511). This file contains detailed information on a number of different religious and ethnic groups, including Moslems, Baha'is, Sikhs, Cambodians, Bosnians, Vietnamese, Iranians, Maori, Polish, Serbs, Italians, Portuguese and others. It may be useful to store this tool in the pocket of the Culture and Health Care file.

Another way to access information about specific cultures is to visit the Queensland Government's Cultural Diversity website at **http:// www.health.qld.gov.au/hssb/cultdiv/home.htm**

While we cannot expect to capture the complexity of culture in this small resource, we hope it becomes a step in the direction of enhancing cultural competence among mental health practitioners.

WHAT IS "MENTAL ILLNESS"?

Mental illness has been described by the DSM-IV manual (American Psychiatric Association, 1994) as clinically significant behavioural or psychological syndromes or patterns that occur in individuals.

The following factors may be associated with mental illness:

- Distress (eg. feeling very sad or very anxious); and/or

- Disability (eg. problems with work or family relationships); and/or

- An increased chance of pain, disability, loss of freedom, death, or suffering.

Mental illness must be a response that is not considered "normal" within the sufferer's culture (eg. feelings of sadness when a loved one dies) and be viewed as either a psychological, or biological, or behavioural dysfunction in the individual.

There are a wide range of problems identified by DSM-IV as a mental illness. The more common ones include:

- Anxiety (eg. agoraphobia, post-traumatic stress disorder)

- Mood disorders (eg. depression)

- Personality disorders

- Psychotic disorders (involving a loss of touch with reality) such as schizophrenia

THE INFLUENCE OF CULTURE

What exactly do we mean by culture? According to Chrisman, culture "... provides people with ways to make sense out of life, aiding in imposing meaning on thoughts, behaviours and events, and allowing us to make assumptions about life and how it ought to be led" (Chrisman, 1991).

- All people are cultural beings.

- Culture influences all people's norms, values and behaviours.

- Culture influences how all people understand, interpret and respond to themselves, other people and the world around them.

- Because of culture, all people are inclined to be ethnocentric.

- Despite the strength of cultural influences, individuals within any culture will vary considerably.

For those working with people from other cultures it is particularly important to try to overcome one's ethnocentrism.

The universal phenomenon of ethnocentrism occurs when all behaviours and actions are judged according to the standards of one's own culture. For example, many Australians do not understand why some Moslem women cover their entire bodies, hair and faces. Such actions are viewed as 'strange', anachronistic or oppressive. This is an example of a judgement according to the standards of one's own cultures.

When individuals from one culture find themselves living in a different cultural context, one of four processes may occur, namely assimilation, integration, separation or marginalisation (Berry, 1997).

Integration: maintaining own group values and beliefs, as well as those of the larger social context to an extent.

Assimilation: non-dominant group does not maintain identity and seeks daily interaction with other cultures.

Separation: maintaining own culture and avoiding interaction with other cultures.

Marginalisation: contact with own and other cultures is avoided.

Different individuals will experience different degrees of each process at different points in time. Migrants and descendants of migrants in Australia may be acculturated to different degrees. There is some evidence to suggest that integration is the approach most likely to be associated with positive health outcomes (Berry, 1997) although this remains to be fully addressed in different cultural contexts.

It is important to be aware of a number of traps that can occur in making assumptions about cultural influences. Any attempt to raise levels of cultural awareness runs the risk of stereotyping those from different ethnic groups (Carrillo, 1999). Stereotyping involves making assumptions about the characteristics of an individual, which are based on a standard, simplistic characterisation of their culture.

Within any culture, individuals will vary considerably – they may adopt values,

beliefs and behaviours that are idiosyncratic or unusual from the perspective of their cultural background (Ridley et al., 1998).

It is easy to ignore the influence of class or socioeconomic status on attitudes, beliefs and actions, but class differences within a culture are often more significant than differences between cultures.

Cultures themselves are never static. They undergo change as a result of changes in technology, external influences such as satellite television, and internal influences such as migration. Generalisations about cultures, while useful pointers, should never be taken as applying to any given individual.

MENTAL HEALTH AND MENTAL ILLNESS AMONG CULTURALLY DIVERSE COMMUNITIES

Currently, the management of mental health and mental illness in CALD communities is lacking with regard to cultural awareness and sensitivity (Kleinman et al., 1987; Castillo, 1997; Rooney et al., 1997; Blignault et al., 1998; Ridley et al., 1998). This is the case for those experiencing a mental illness as well as the carers of the mentally ill (Lefley, 1989, 1985; Guarnaccia and Parra, 1996; Aranda and Knight, 1997; Finley, 1999; Kokanovic et al., 2001; Rooney et al., 2000). It is important to understand the definition of mental health and illness being used in this booklet as well as key factors that may be underlying the causes of presenting problems in CALD clients.

A holistic approach to mental health incorporates all those factors which may contribute to the better adjustment and greater sense of well-being of an individual or group. In a CALD context there are a number of factors to consider which may be crucial to the mental health of individuals or communities. These include:

■ pre-migration:

■ the process of resettlement;

■ response to the stressors of the dominant culture.

These factors are potential environmental sources of stress and conflict which may contribute to the expression and experience of mental illness.

BELIEFS ABOUT THE CAUSES OF MENTAL ILLNESS

People believe mental illness to be caused by many different things, including biological, psychological, social, migration, cultural and religious factors. A number of authors (Kleinman et al., 1978; Castillo, 1997; Ridley et al., 1998; Rooney et al., 1997) have noted the following factors and beliefs.

Biological factors:

- Heredity
- Contagion

Psychological factors:

- Lack of personal resources (eg. energy)
- Low self-esteem
- Lack of self-confidence
- Personality and temperament
- Frustration from inability for self-expression
- Negative thoughts
- Depression related to stress
- Negative affect/attitude
- Loneliness (isolation)
- Feelings of professional inadequacy

Social/migration factors – before arrival:

- Stress of preparing to flee, fleeing, seeking asylum and the process of resettlement

- War and political instability

- Torture and physical abuse

- Brainwashing (forced indoctrination)

In transit factors:
- Stressors involved in living in refugee camps

- Stress of travelling as a refugee

Social/migration factors – after arrival:
- Lack of acceptance in country of resettlement

- Antisocial and illegal behaviour

- Stress of migration process

- Change in lifestyle and socioeconomic status

- Unemployment

- Racial discrimination

- Supporting family in home country

- Financial stress

- Stress of separation from family members in home country or other countries of resettlement

- Alcohol and drugs

- Family dysfunction

- Australian system of education and attitudes to parenting

- Dissatisfaction for old people

- Denying cultural origins and refusing contacts with community. The lack of support and stress that results from this may contribute to the development of mental illness.

Cultural and religious factors:

- Evil spirits

- Bad karma

- Migration (leaving one's village, town or land)

- Bad deeds

- Disengaged community

- Torture and trauma in country of origin and refugee camps

- Cultural alienation

- Language barriers

- Women's role in society (eg. isolation and abuse)

While some of these factors do not have negative connotations (eg. social factors causing stress such as migration, cultural alienation, loss of status, and language barriers), others (a disease you can catch, evil spirits and karma) hold varying degrees of negative association for those living with a mental illness, ie:

- Mental illness occurs because of bad deeds

- Mental illness is a result of criminal behaviour

- Mental illness occurs as the result of a previous bad life in one's ancestry. Some people think it means that ancestors such as their grandparents, uncles or aunties must have done something bad in their lives and people in the current generation are paying for it.

- Mental illness is a result of bad karma

- Mental illness is caused by evil spirits

- Mental illness is a disease that you can catch

- Talking about mental illness can lead to mental illness

- If you help someone with a mental illness, you and/or your family may be regarded with many of the associations reserved for those with a mental illness

- Often the family is viewed as an extension of the individual so the attitudes and behaviours that are directed towards someone with a mental illness are also directed to their family

The beliefs outlined above can impede the acceptance of the mentally ill or mental illness information. They encourage people to blame those who have a mental illness, perceive them as weak, spiritually bad, or dangerous. There are a number of reasons, including those beliefs, which result in a reluctance by members of communities to accept those living with a mental illness. These attitudes need to be kept in mind and dealt with in a sensitive manner when dealing with mental health issues (Bakshi et al., 1999).

HOW CULTURAL DIVERSITY AFFECTS THE MANAGEMENT OF MENTAL ILLNESS

Culture "affects the way people label illness, identify symptoms, seek help, decide whether someone is normal or abnormal, set expectations for therapists and clients, give themselves personal meaning, and understand morality and altered states of consciousness" (Ridley et al., 1998).

Castillo refers to the five ways in which culture affects the clinical interaction (Castillo, 1997) as:

- Culture-based subjective experience – attitudes, feelings and behaviours which are defined by, and constructed within, a particular cultural framework eg. grief, love, shame, pride and associated behaviours.

- Culture-based idioms of distress – ways people act to express their illness.

- Culture-based diagnoses – indigenous practitioners' methods of assessing and diagnosing the problem, as per local culture.

- Culture-based treatments – appropriate treatment within the cultural meaning system.

- Culture-based outcomes – outcomes will be based on how the illness has been culturally constructed and treated.

Like health care in general, culture-sensitive care is based on the principles of knowledge, mutual respect and negotiation.

Culturally Sensitive Clinical Practice

When the players in a clinical interaction are from different cultural backgrounds, the clinician client relationship may be problematic. It is critical,

therefore, for practitioners to attend to (a) their attitudes and feelings about clients (b) their clients' attitudes and feelings toward them, and (c) the degree of synergy that results when these are expressed within the clinical setting (Ridley et al., 1998).

A major obstacle to negotiation between clinician and client is ethnocentrism, in particular, medical ethnocentrism where biomedical beliefs dominate to the exclusion of others. Common manifestations of ethnocentrism in the clinician client relationship are laughter, surprise, incomprehension, anger and shock.

The dangers associated with medical ethnocentrism include, but are not limited to, perceived threat and reluctance to disclose information. To circumvent these obstacles and promote understanding and negotiation requires an understanding of the behaviours and beliefs of the client within the parameters of the client's culture rather than the clinician's culture – cultural relativism. Adopting this process is a pre-requisite for negotiation between clinician and client in health care settings (Chrisman, 1991).

Cultural Assessment

The following checklist has been adapted from Allotey et al., (1998). They may be important points to consider when assessing people from cultural backgrounds different from your own.

- Where the client was born and how long they have been in the country

- What the client's ethnic affiliation is

- Who the client's major support people are

- What the client's primary and secondary languages are, and their reading and writing abilities in these

- What their non-verbal communication style is like

- What the client's religion is, and its importance in their daily life

- Whether the client's income is adequate to meet the needs of the client and their family.

EXPLORING EXPLANATORY MODELS

How we communicate about our health problems, the way we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate that care are all affected by cultural beliefs.

Illness is shaped by cultural factors governing perception, labelling, explanation, and valuation of the experience. Because the experience of illness is an intimate part of social systems of meaning and rules for behaviour, it is strongly influenced by culture (Kleinman et al., 1978). An explanatory model includes the beliefs, concerns and expectations a person has about their illness experience and the medical encounter.

Divergent explanatory models, based on different cultural perspectives and social roles, can lead to problems in mental health settings. Mental health professionals typically approach mental illness from the biomedical model. Clients will frequently view their mental illness differently. It is important to recognise the model(s) of mental illness that individuals from diverse cultural contexts have. Failure to do so can lead to a number of negative consequences, including misunderstanding, the loss of the client and poor treatment outcomes (Rooney et al., 1997).

The Biomedical Model (Kaplan and Saddock, 1998) recognises the influence of a number of factors, including culture.

The Bio-Psycho-Social Model

When a person develops a mental illness, it is because of a complex interaction between biological, psychological, and social and cultural factors.

Biological Factors: The type of genes (eg. tendency to become extremely anxious under certain situations) that they have inherited from their parents.

However, biological factors causing psychiatric disorder may also have organic attributions eg. toxicity, drugs, etc.

Psychological Factors: Their psychological resources (eg. self-esteem or how good they feel about themselves).

Social Factors: What is happening in their lives (eg. a stressful situation such as loss of a partner).

Cultural Factors: The cultural values, beliefs and behaviours in a person's environment (eg. child-rearing expectations).

> *Using a purely biomedical model is inadequate for appropriate assessment and treatment in a multicultural society (Kleinman et al., 1978).*

The Bio-psycho-social-(cultural) Model of mental illness is widely accepted in Western countries. It is important to remember that this framework may not always fit with the client's framework especially if they are from a different cultural background.

The conceptualisation of the illness experience includes the signs and symptoms by which the illness is recognised, the understanding of the cause, severity and prognosis of the illness, the expected treatment, and how the treatment affects a person.

Explanatory models help explain:

- why something happened:
- why it happened to that particular person at that particular time and in that particular way;
- how it came to happen or what caused it;
- what should happen over the course of time;

- what should be done about it;

- what will happen with a given response.

(Fitzgerald et al., 1996).

> *Explanatory models are employed by all those engaged in the clinical process. Both practitioners and clients utilise explanatory models. Health professionals and clients typically accept their respective models of the problem at hand without question, and fail to compare them with each other (Ridley, 1998). In order for progress to be made, these models need to be explored.*

A common issue in mental health is determining whether or not a particular situation or behaviour is evidence of an illness, or if it reflects a cultural difference in normal behaviour (Fitzgerald et al., 1996).

Recognising explanatory models and accessing a patient's and family members' explanatory models will provide the practitioner with information about any cultural health beliefs and practices relevant to the individual's mental health presentation. Various folk beliefs, alternative medical practices and illness behaviours that may influence the patient's understanding, presentation and treatment may be revealed (Carrillo, 1999). Practitioners must beware not to make an assumption about a patient's perspective without seeking evidence from the patient to support the conclusion.

> *With the knowledge of the patient's explanatory models about illness, you will be able to effectively negotiate with the patient a treatment approach that will be acceptable and effective for the patient.*

ISSUES TO CONSIDER DURING A CROSS-CULTURAL CLINICAL CONSULTATION

While it is important not to generalise about individuals from ethnically diverse backgrounds, there are often common characteristics resulting from cultural differences, which may impact upon the clinical interaction and treatment. The individual must be treated within the context of their cultural influences, and the best way to understand those influences is to use the CAT. The following points may alert you to some common issues.

- Clients may use traditional or folk healing methods concurrently with Western medical treatments.

- Western medicine tends to be very individualistic, whereas other cultural knowledge systems may be more holistic.

- Family may be very important. It may be important to include the family in consultations about the condition and treatments.

- Family configurations may be different to the Western nuclear style. Extended families and patriarchal values may be common.

- Be aware of differences in values. Some cultures value pride, self-reliance and self-control, others value submission, conformity and stoicism.For some, displays of emotion are encouraged, for others the hiding of emotions is the norm.

- Gender issues within a given culture may be very significant. For example, the status of women may be central to their experience of the presenting problem, hence influencing their well-being.

- The elderly may suffer specific stresses related to language problems, economic dependency and role changes.

- For refugee populations, intolerable suffering may have been experienced. This may result in post-traumatic stress disorder and other conditions including depression, anxiety and somatisation. They may be survivors of torture and trauma associated with war and political upheaval, victims of domestic and sexual abuse, victims of violent crimes, survivors of natural disasters and accidents, and witnesses to any of these events.

- The client may feel shame or be reticent in openly discussing his/her reactions to trauma or loss, and their cultural expectations for a given situation may be significantly different from the Australian norm. This may need sensitive recognition and response.

- Adolescents may be torn by competing desires to fit in and adopt the dominant culture, and to obey their families. They may be thrown into an adult role at a young age, due to language skills and work opportunities.

- Some cultures use terms like "nerves", "wind", "cold" or "hot" to explain or describe symptoms.

- Attitudes to medical treatment may differ.

- Many societies do not have a tradition of professional talk-based therapies, so these may be regarded with suspicion.

- Some clients from CALD backgrounds may prefer clear dignoses and active treatments.

- CALD carers of family members with a mental illness frequently face difficulties related to the stigma of having a mentally ill family member. Specifically, these include practitioners' tendencies to overlook the influence of carers in the treatment process, and a poor fit between cultural conceptions of mental illness and treatment received.

- Respect for the client's cultural background and for their explanatory model of the presenting problem constitute a key element of the interaction and successful engagement in the treatment process.

USING THE CULTURAL AWARENESS TOOL

The Cultural Awareness Tool (CAT) has been designed to enhance your understanding of the patient's perception of their problem. Such an assessment acknowledges the complexity of the interaction between cultural and idiosyncratic factors, and between dispositional and environmental factors, and will necessarily involve considerable subjectivity on your part. The tool is based on a series of questions developed by Kleinman, Eisenberg and Good (1978).

The Cultural Assessment Tool involves asking the patient the following questions:

1.   What do you think caused your problem [use patient's words *]?

2.   Why do you think it started when it did?

3.   What do you think your [*] does to you? What are the chief problems it has caused for you?

4.   How severe is your [*]? What do you fear most about it?

5.   What kind of treatment/help do you think you should receive?

6.   Within your own culture, how would your [*] be treated?

7.   How is your community helping you with your [*]?

8.   What have you been doing so far for your [*]?

9.   What are the most important results you hope to get from treatment?

Questions should be asked gently, leaving the client plenty of time to consider their replies and to expand on them. It is important that sensitivity is applied

when posing these questions. In some cultures, a less directive approach of questioning is more acceptable where the questions may be 'embedded' throughout general conversation with the CALD background client. For example, after having engaged the client, one might ask *"what do you think might be some of the reasons that your problem occurred?"*. The aim is to understand their view of their condition, within the context of cultural influences. It is also useful to understand aspects of the client's life that may be assisting them to maintain positive mental health eg., social support network, diet, exercise.

Crucial for eliciting an explanatory model is:

- *a genuine, non-judgemental interest in the patient's beliefs;*

- *communicating to the patient that this interest is to gain knowledge*

that is vital for planning effective treatment.

The therapeutic relationship between the practitioner and his/her client plays a central role in facilitating subsequent treatment efficacy. The Cultural Awareness Tool is a means to assist you to establish the crucial therapeutic alliance, gaining rapport with your patient and building trust. The formation of an effective working relationship between yourself and the CALD client implies that a negotiation process can be entered into by both parties in developing culturally appropriate management and treatment plans.

Negotiating a treatment plan

With the knowledge of the patient's explanatory model of illness, the practitioner can effectively negotiate with the patient a treatment approach that will be acceptable and effective for the patient. Such a negotiation will involve the following steps:

1. Eliciting the client's explanatory model;

2.   outlining the practitioner's explanatory model;

3.   comparing the models;

4.   conceptually translating and negotiating an understanding and acceptance of one model with the other;

5.   developing a mutually acceptable treatment plan.

In some cases it may be possible to combine different treatment methods, for instance through the use of medication, a traditional cultural broker and traditional remedies.

CULTURAL FORMULATION OF A PSYCHIATRIC DIAGNOSIS: A CLINICAL CASE STUDY

DEATH ON A HORSE'S BACK: ADJUSTMENT DISORDER WITH PANIC ATTACKS

CLINICAL HISTORY

Patient identification. Nguyen Van Nam[1] was a 33 year old man, married with two daughters, aged five and two. His wife was expecting a third child. They lived in their own house in a suburb of an Australian city. Nam was unemployed. He had been living in Australia for three years when he first accessed the mental health service. He had sought treatment at a large general hospital in the city, and had been referred from the emergency department to the outpatient department for an urgent psychiatric assessment. His wife accompanied him. Nam could not speak English. Arrangements were made for an interpreter, Mr Le Van Tam[2], to assist with the assessment.

History of present illness. Through the interpreter, Nam said that two weeks previously he became unwell while making love to his wife. Suddenly (he put his right hand to his abdomen and crouched forward as he spoke) he was caught by "a ball of wind," *một cục gió*, which moved about inside him, leaving him with a stomach ache lasting two hours. For a fortnight, this ball of wind moved up and down his body; when it went up, he could not breathe and his chest would become tight and numb. This would be relieved by means of *cạo gió*

treatment, scratching the skin to "draw out the wind," but the symptoms kept recurring. He also reported having no energy, with severe weakness, especially in the limbs.

Nam had already presented to a small, local hospital near his home, where the doctor performed a sigmoidoscopy, a procedure which, according to Nam, relieved the problem for several days because it released a considerable amount of wind from his body.

On Saturday, three days before he was assessed at the psychiatry outpatient clinic, the ball of wind moved up towards his neck, making his head feel numb. He was taken by ambulance to a larger general hospital, where a physical examination was carried out and an x-ray of his abdomen was performed. Nam said that the doctor allowed him to go home, reassuring him that although a slightly increased amount of wind in the intestine was visible on x-ray, this was not a serious problem.

On Sunday evening, the ball of wind went up to his neck, becoming stuck in his throat where it led to breathing difficulty, and ultimately caused him to suffocate and faint. His wife called friends and family to the house to help, and he vaguely remembers someone blowing air into him (mouth to mouth resuscitation), his brother-in-law giving emergency scratching treatment to release the air, and the "Australian" neighbours calling the ambulance which brought him to hospital. Medical staff in the emergency department formed the opinion that psychological factors played a major role in Nam's symptoms, so they referred him for psychiatric assessment on the following day.

Nam reported that during the previous two weeks he had experienced 3-4 episodes of being affected by wind each day, and these episodes were worse in the evening. He was only sleeping two hours per night, kept awake by a rapid, pounding heartbeat.   There was no history of sweating, perioral or finger paraesthesiae, or depersonalisation.   His appetite was poor and there was possibly a small amount of weight loss, though there was no history of depression or sadness in the period leading up to this illness, nor were there

thoughts of worthlessness, guilt, hopelessness or suicide. There were no intrusive recollections, recurrent dreams, reliving of war experiences, hyper-arousal, avoidance or numbing, that might have pointed to a diagnosis of posttraumatic stress disorder.

Nam gave a history of pain in the right testicle which had been present on and off for many years, but which had persisted during the period of this illness, commencing during intercourse and spreading upward so that it felt like it was coming from inside his abdomen. Nam stated that, when he was nine, he had been climbing a tree when he fell a considerable distance, landing astride on one of the lowermost branches. He remembered that the skin of his scrotum split open to reveal white looking flesh, which was his testicle. A nurse bandaged it. He was frightened. One week later it had not healed. His father took him to hospital where it was sutured. Asked about recent events in his life, Nam said he had just travelled to another Australian city for the funeral of his uncle (mother's brother) who had died of lung cancer. Nam saw him lying in the coffin dressed in a suit, his stomach distended. Two weeks ago, during the bus trip home, he had developed a fever and a running nose, and had begun to feel "weak." On arriving home, and while still in this weakened state, he had made love to his wife and this was when his illness began. His uncle, he said, had not held a special place of importance within the family and indeed, Nam only felt a little sad, never having known this uncle well. When asked about the potential spiritual danger associated with death, Nam stated that while the soul of a dead person may wander in the vicinity of the body for 100 days, it is not known to cause illness.

Nam's wife corroborated the presenting history. Her worried expression, anxious questioning about her husband's problems, and what would be done for him, underlined the grave concern with which this illness was treated by the family. She reported that on Sunday evening he had become completely unresponsive and that his pulse had actually stopped. She said he had "died momentarily." She was expecting to deliver in two months. They did not know

the sex of the child, but Nam was hoping for a son, though he said he would be happy for a son or a daughter.

Psychiatric history and previous treatment. He had never before received psychiatric treatment.

Social and developmental history. Nam was born in a small hamlet very close to a town of some 10,000 people, the administrative centre of a district within a Vietnamese province close to the Cambodian border. This region was originally Cambodian but had, many centuries ago, been overrun by the Vietnamese and so it had a mixed culture and language. Nam was the third of nine siblings and the oldest son. He attended school for seven years from the age of nine, and at 16 began to run his father's farm. His father owned a relatively large holding, mainly growing rice and vegetables. As a landholder and an educated man, his father was appointed to an official post within the town, becoming responsible for a range of administrative duties including tax collection.

The war formed a backdrop to Nam's childhood. On initial assessment, he was reluctant to talk about it, but later, as rapport was established, he began tentatively to discuss his experiences during that period. "Too many people died," he said. As a boy, he used to go down and watch corpses being carted on ox-carts for burial or burning. Some had lost limbs, others were headless, sometimes there was only a trunk. In the long run, he said, this did not affect him badly: "in the end we got used to it."

When Nam was 16, his father was killed by Viet Cong soldiers in a house about a kilometre from their home. Nam remembered being woken at night to the sound of gunshots. Later that night, the neighbours brought his father's body home, wrapped in a blanket. He remembered his father's closed eyes and, when the blanket was unwrapped, blood all over his chest: "I cried and cried."

Communist forces took complete control of the province when he was 19, seizing half the family farm and attempting to draft him into the army. To avoid

this he was forced to hide in friends' houses from time to time.

At age 26, the government having completely confiscated his land, Nam left Vietnam in an 11-metre boat that had been organised by his brother-in-law's father. There were 58 people in the boat. They first landed in Malaysia where Nam lived for four years in a refugee camp housing some 6,000 to 7,000 people. He met and married his wife there.

The couple were accepted into Australia when Nam was 30 and they had since bought a small house with three bedrooms, with the help of a bank loan. Nam had undertaken a welding course but then worked intermittently as an unskilled labourer, unable to find permanent employment. He was receiving unemployment benefits. Their older girl, aged five, was attending a pre-school; the younger one was aged two.

Family history. Nam said, with special emphasis, that there was no history of psychiatric illness in his family.

Course and outcome. The course of this illness was brief and its outcome was good. After initial assessment, admission to the acute psychiatric ward was arranged for the purpose of a full diagnostic work-up, providing opportunity to carry out the time-consuming interpreter-assisted interviews that this would require. It also enabled an in-depth assessment of the impact of the illness on his wife, and provided a comprehensive picture of his extended family support network. Opportunity was also afforded for the clinical team to meet with his brother-in-law (his elder sister's brother), who emerged as the most important figure in the wider family constellation. It was under the auspices of that person's family that Nam had been able to leave Vietnam. Hospital admission was reassuring for Nam, for it served to underline the seriousness with which one was treating his condition. Treatment in a psychiatric ward of a general hospital, with its medical atmosphere, had significant advantages for Nam over treatment in a traditional mental hospital, which might have carried negative connotations of mental illness for him. The treatment is discussed below, following the diagnostic and cultural formulation. Suffice to say at this point,

that it combined Western psychiatric interventions (support, clarification, education and exploration of emotional issues, as well as with a low to moderate dose of a tricyclic antidepressant) and a traditional Vietnamese intervention (coin scratching). The contact which the clinical team established with Nam's brother-in-law was crucial in this regard, for it transpired that he had been applying this scratching treatment on a regular basis, yet furtively, fearing we[3] might disapprove. When it was explained to Nam that we conceived the treatment as a joint enterprise combining Western and Vietnamese interventions, there was a considerable sense of relief on the part of Nam and his brother-in-law. There was also an increased acceptance of our view of the illness and our treatment plan.

Quiet and inactive on the day of admission, Nam was observed to be brighter and more reactive by the second day. For the next three days he again became withdrawn but then began to make a substantial improvement, appearing more responsive and involved each day. He increasingly made attempts to work around the language barrier to interact with other patients. Nam had no further episodes of fainting and the symptoms associated with wind diminished over the course of a week. He was then discharged home, to be followed-up on an outpatient basis at fortnightly intervals. At first he reported some persistent wind coming from his stomach, though not to the same degree as previously, and he remained otherwise free of symptoms in the period up to and following the birth of their first son.

Following discharge from hospital the pivotal event in his trajectory of recovery was the birth of his son, after which he reported no further symptoms at all. Given the embargo on sexual intercourse following birth, there was no opportunity to ascertain whether Nam was able to make love to his wife without again being struck by a ball of wind. One month later, his care was fully transferred to his primary care practitioner, a Vietnamese speaking doctor. After six months the imipramine was reduced and then ceased.

His recovery was sustained over a longer term, with no recurrence of panic attacks or bodily symptoms, and no sexual dysfunction. After a year he secured regular employment as a farm labourer.

DIAGNOSTIC FORUMULATION

Axis I: 309.24 Adjustment Disorder (with Panic Attacks the most prominent aspect of the clinical picture).

Axis II: Deferred because available categories are culturally inappropriate.

Axis III: None currently active.

Axis IV: Previous experiences of war and migration – severe.

Unemployment and financial strain – moderate.

Lack of development of English language skills – moderate.

Social isolation – mild.

Death of uncle – mild.

Impending birth of child – moderate.

Axis V: Highest past year GAF (Global Assessment of Functioning) = 90

Current   GAF = 60

Differential diagnosis: Panic attacks were the main feature of Nam's symptom pattern. Although a strong argument could be made for a principal diagnosis of Panic Disorder (300.01), strictly speaking, however, the length of illness criterion for this diagnosis was not satisfied. The attacks had only been present for only two weeks. The principal diagnosis of Adjustment Disorder has the advantage of conveying the reactive nature of this illness. The symptoms of weakness, loss of energy, insomnia, and loss of appetite and weight, certainly raise the possibility of Major Depression (296.2) but the brief duration of the illness would argue against a major depressive episode. Moreover, symptoms of panic predominated over feelings of sadness or depression. Finally, the

diagnosis of Posttraumatic Stress Disorder (309.81) was entertained in light of his experiences of war and migration, but insufficient clinical criteria were met to establish this diagnosis.

CULTURAL FORMULATION

A. Cultural identity

1. Cultural reference group(s).   Vietnamese by ethnic identity, Buddhist by religion, and nationalist by political persuasion, Nam came from a border region characterised by a diversity of cultural and linguistic influences – Vietnam, Chinese and Cambodian.

2. Language.   Nam's mother tongue was Vietnamese.   After three years in Australia, he spoke very few words of English, though he said he could understand English better than he could express it.

3. Cultural factors in development.   Cultural influences on his development, in the sense of those aspects of his upbringing which were uniquely Vietnamese, pale by comparison with the effects of the persistent warfare that overshadowed Nam's childhood, adolescence and early adult years; the war provided a backdrop of death to his boyhood and radically altered the destiny of his family.

4. Involvement with culture of origin.   Nam identified himself as Vietnamese. Just a few hundred metres away from his suburban home in Australia lived one of his younger brothers, an elder sister and her family, and a cousin also lived a little further away. He kept in regular contact with them. He had no contact with the ethnic community organisations (see below under *Social supports).* His mother still lived in Vietnam, three brothers and a younger sister remaining there with her. He corresponded with her and regularly sent her small sums of money.

5. Involvement with host culture.   Involvement with the host culture was minimal. Nam's daily routine included attending an employment centre to seek work, and taking his child to and from school. He had little interaction with

neighbours who were not of Vietnamese background, and referred to this as "Australian," even though he too was an Australian citizen. Each weekday, however, he watched 'Neighbours,' a uniquely Australian television serial – a distillation of Australian popular culture – and he enjoyed this.

B. Cultural explanations of the illness

1. Predominant idioms of distress and local illness categories. According to Nam, his condition was called *trúng gió.* Literally speaking it means "to be hit by a wind" or "to be caught by a wind," though this idiom usually refers to a symptom complex of weakness, headache and dizziness, progressing in severe forms to collapse. Just as one might say in English that the sun could cause sunstroke, so in Vietnamese, you can say that the wind can cause "wind-stroke." In the context of Nam's complaints, it could be taken to mean that he was caught by a wind "while making love." Nam introduced another relevant term, *thúọ̣ng mã phong*, a droll expression derived from archaic Sino-Vietnamese language, which more directly alludes to sexual intercourse. A literal translation of each word directly alludes to sexual intercourse. A literal translation of each word, however, does not convey the full sense, for *thúọ̣ng* means "on" or "above", *mã* means "a horse" or "something that travels very fast", and *phong* is a word derived from Chinese that means either "wind" or "sickness". The whole phrase conveys an image of being struck down by a wind illness while galloping at full speed, and it refers to a sudden collapse during sexual intercourse at the point of climax. Mr Lê searched for an idiomatic translation that would capture the nuance of Nam's expression and related it to his particular history of the illness. "To be hit by a wind in the bedroom" was too obscure. "Sudden death in the act of love" was too explicit. "Wind-stroke at full gallop"? He finally settled on "Death on a horse's back."

"Wind," "loss of semen," and "weakness" were the three central idioms of distress. Under the rubric of "death on a horse's back," each of these three idioms was linked to the other two, forming a cluster of meanings that

encompassed both the causes of the condition and its chief symptoms.

2. Meaning and severity of symptoms in relation to cultural norms. Nam regarded his condition as dangerous and feared that he might die of it. The Vietnamese expressions he used drew on the parallels between fainting and death. One Vietnamese term for fainting translated to mean 'a momentary death', though a person is still breathing while in this state; whilst another term describes a person who is no longer breathing and appears dead, as if pretending or shamming death.

4. Perceived causes and explanatory models: "Death on a horse's back," as we came to call Nam's illness, is a well recognised syndrome, though rarely does it result in a fatal outcome. Mr Lê having been personally aware of only two to three deaths that were attributed to this cause over about 30 years. A Vietnamese king, according to legend, may have died from this condition. It is caused by having sexual intercourse while in a weakened state, semen being "squeezed" out of the man, who may actually die on top of his wife. In traditional Vietnamese society, young women are taught, in this event, not to push their husband out of them. The best thing to do is quickly take a sharp object, say an ear pick kept in your hair bun, then, reaching over your husband's back, jab him quite hard on the coccyx until he starts moving again. This remedy pricks the bone, stimulates the husband's nerves, and brings him to life again. Only then should the woman think of using other remedies, such as the scratching treatment. Mr Lê conveyed this information with a broad grin on his face and, indeed, this topic is a common source of ribald amusement among men, who might crack jokes about it when they are sitting around drinking together. Women, as well as men, are vulnerable if they have sexual intercourse within the first 100 days of giving birth, though the mechanism in this instance obviously doesn't involve semen loss.

A Vietnamese phrase is used to describe the state of weakness that renders one vulnerable to this illness. The literal translation is a feeling that you have 'no strength'. Another phrase he used translated as 'a weakness in the body' and, in

Nam's case, it was associated with a weakness of the spirit or the emotions.

Sexual intercourse while weak also renders one vulnerable to an attack of "wind," a common cause of illness throughout Southeast Asia. Among Vietnamese people, Nam said, it could cause a variety of problems including rheumatism, headaches, stomach aches. He stressed that wind only causes physical problems; it does not affect mental health. Mr Lê described wind as potentially "vicious" and harmful. People avoided exposure to currents of air as the wind could enter the body and is then unable to exit, causing weakness, collapse, and death. Children are especially vulnerable to wind, which can make them faint or "strike" them dead. Babies are never allowed to sleep exposed to wind, lest it makes them cold by entering their body, causing illness or death.

Nam drew a clear distinction between "Death on a horse's back" and mental illness, emphasising that it was a condition affecting one's body, one's spirit and one's emotions, but did not affect the brain and did not lead to "craziness." Mr Lê agreed with this opinion.

Both Nam and Mr Lê were also quite clear that spirits did not cause Nam's symptoms. Spirits are known to penetrate the body causing illness, but in such cases the symptoms would be different: talking nonsense, doing silly things, becoming violent. Nevertheless, they drew links between wind, on one hand, and spirits or ghosts on the other. Mr Lê cited a classic Vietnamese poem he remembered from childhood that told of people visiting a cemetery in springtime and being affected by ghosts that ride in on the wind. He explained that a baby, once having been hit by wind, can then be harmed or punished by spirits and it will fall ill. When his own child fell ill, Mr Lê's grandmother would burn an incense stick and offer food to spirits to protect the child. While Nam's illness was caused by wind, not spirits, the wind that had entered his body did render him vulnerable to being affected by spirits.

Loss of semen, another illness concept widely reported throughout Asia (Bottéro 1991), may be explained in two ways. Firstly, it was a loss of *tinh trúng*, or spermatozoa. *Tinh* may be translated as "essence" and *trúng* as a "minuscule

organism". Thus sperm is regarded as containing the essence of one's life which is passed on in the creation of a new person. At the same time, there was a loss of *tinh khí,* "seminal fluid"*, khí* meaning "air", "wind" or "energy". *Tinh khí* thus carries the additional meaning of "vital essence" or "energy". Mr Lê called it "our spirit enhancer," a vitality that energises thinking, judgement, and emotions. Put together, the two terms could be understood as a loss of one's essence and vitality – reproductive vitality and vitality of spirit.

5. Help-seeking experiences and plans. Skin scratching, *cạo gió,* is a standard domestic remedy, said to have its origins in traditional Chinese medicine. It is usually done with a coin, preferably an heirloom, or a spoon; the skin is prepared with ointment, *dầu gió*, commonly one that has "hot" properties. The scratching should be hard enough to raise a weal, but the ointment prevents the skin from breaking down. This procedure not only releases air but strengthens the nerves. At the same time, Nam repeatedly sought hospital treatment.   It has been observed in the medical anthropology literature, and Nam was no exception here, that traditional healing and modern Western medical treatment are commonly pursued simultaneously.

C. Cultural factors related to psychological environment and levels of functioning

1. Social stressors. Nam was unable to secure regular employment. Repaying his mortgage was a major financial commitment and the coming birth of a child may have represented some additional financial strain. Though Nam did not place much emphasis on the importance of having a son, it was considered that this might have been the most significant issue of all. It was also suspected that his uncle's death may have unsettled Nam, but again, he said that it had not been a factor.

2. Social supports.   Having family members living close provided the main source of support, and his brother-in-law played a particularly important role as the senior member of the wider family.   Even so, in a nostalgic mood, Nam

contrasted his current situation with how it used to be in Vietnam, where the doors were always open, and you could see your relatives every day. Here in Australia, he explained, you need some means of transport to visit them, even when they live quite near. Consequently, you tend to visit only at weekends. Nam and his family did not seek support from the many organisations and clubs that were available to them. The variety and number of these clubs reflected cultural, linguistic, and religious differences among the immigrant community, for they included an Indochinese Association, a Vietnamese Community Association, a Vietnamese Buddhist Association, a Vietnamese Christian Association (predominantly Roman Catholic), and an Indochinese Women's Association. Among these cleavages, the deepest divisions were still determined by political affiliation. "We try to live as one, but it is not easy," said Mr Lê. "We don't know who is nationalist and who is communist – a blanket of suspicion covers our community."

3. Levels of functioning and disability. Following the period of acute illness, Nam's social functioning recovered rapidly, enabling him to resume his role within the family. However, even by the time direct clinical involvement was appropriately terminated, it was still too early to assess whether there was any residual sexual dysfunction. He also reported that, at this stage, he was only ready for light work, indicating that there was room for further recovery in this area of his functioning.

D. Cultural elements of the clinician-patient relationship

In contemporary hospital practice, the concept of a "clinician-patient relationship" does not accurately reflect the nature of a clinical interaction, for we are not dealing with a dyadic relationship so much as an encounter between two groups of people. On the one hand there is the patient and his family members (in Nam's case, his wife and brother-in-law) and on the other hand, there is a team of professionals (here, the psychiatric nurses, the social worker, the trainee psychiatrist and myself, the psychiatrist). On Nam's side, his family

members were central to the understanding of his illness and its treatment. In relation to the treating professionals, the nursing staff played a major role in observing Nam's recovery, in supporting him, providing him with information and reassurance with the help of an interpreter, as well as accepting and encouraging his brother-in-law. In spite of language difficulties, the nursing staff was adept at encouraging his participation in daily activities and group activities on the ward. The social worker was involved more directly in supporting Nam's wife, allaying her fears that he might die, ensuring the family had explored all avenues for adequate financial support, and investigating the possibilities for English classes and avenues for increased community involvement, say, through the children's school. The trainee psychiatrist was central to establishing a relationship of trust with Nam, assisted by the fact that he was the one who organised the routine medical investigations and conveyed the results to him. In this case, Mr Lê became a pivotal figure in the clinical encounter. Though Mr Lê and Nam shared the same broad culture, language and religion, their individual backgrounds differed in terms of class affiliation, educational level, and urban versus rural upbringing. The war had affected Nam and Mr Lê differently, and their respective passages to Australia and subsequent lives have been quite distinct. Highly trained in interpreting, Mr Lê was sensitive to the problems that arise when language interpreters insert their own values into the translation, for example, by portraying patients in stereotypes such as "backward peasant." Thus Mr Lê conveyed a sense of respect for Nam and his beliefs.

It was not possible, however, to be strictly limited to Mr Lê's professional ideal of a "direct translation only," for some degree of explanatory elaboration was necessary if a rudimentary understanding of the cultural elements of Nam's condition was to be developed. Mr Lê thus made an important contribution in facilitating understanding of Vietnamese culture, as important as the contribution of Nam himself. Furthermore, Mr Lê's regular presence at the interviews taking place over a three-month period made him a key actor within the therapeutic alliance. It was Mr Lê who helped to significantly clarify the difference between Nam's conception and the psychiatrist's conception of his

condition; it was Mr Lê who provided the possibility of negotiating a rapprochement between these different understandings. As the treating psychiatrist, I became conscious of having to avoid the pitfall of becoming fascinated by Mr Lê's cultural exegeses at the expense of attending to Nam and his suffering.

The educational aspects of this case for the entire clinic should not be underestimated, not only in increasing our knowledge of some of the specific Vietnamese cultural concepts of illness, but also in terms of establishing a modus operandi with patients from other cultural backgrounds, particularly those in which the nature of the illness is difficult to grasp.

E. Overall cultural assessment

There were two explanatory models of illness at work: Nam's understanding of his condition - as outlined above, was grounded in Vietnamese cultural beliefs; and the subsequent clinical understanding proposed that was grounded in the cultural beliefs of Western psychiatry. The team conceptualised his illness as a psychological reaction (adjustment disorder) in which panic attacks were prominent, culminating in at least two full-blown panic attacks. The tachycardia, dyspnoea, paraesthesiae (head numbness), neck tightness (global hystericus), insomnia, anorexia, syncope and fear of death, are all consistent with this picture. Abdominal discomfort and eructation as a consequence of air swallowing can also occur. Our formulation, though tentative, was that this illness was triggered by his uncle's death and, in particular, seeing his uncle's body laid out in the coffin. It was speculated that this scene may have resonated with the memory of father's death and with the memories of the corpses Nam witnessed as a boy. There was little direct clinical evidence to support this hypothesis, although it was noted that despite Nam's initial statement that his uncle played no major role in the family, he later indicated that his uncle had, in fact, cared for him and his family in the period immediately after his father's death. One wondered if there might have been other experiences, even more

numbing, that Nam could not relate or recall. (In our experience, refugees from Indochina who have witnessed atrocities, often find it very difficult in a hospital setting some years later to talk about what they have been through, for fear of reactivating vivid memories and emotions associated with these memories.) Additionally for Nam there was the testicular pain, which may have been linked to the anxiety associated with the near-castrating injury when he was aged 9. These factors may have operated at an unconscious level. At a more practical level, the birth of a third child, while eagerly anticipated, may have constituted a strain on a family that was somewhat isolated from its culture of origin and from its host culture, and whose economic viability was precarious.

Furthermore, in the light of discussions about the high value that may be placed on having a son, it was suspected that Nam was apprehensive about the possibility of having yet another daughter.

In our formulation, the illness was not life threatening. This was yet another point of contrast between our understanding and Nam's understanding of his situation.

The treatment plan was to provide intensive support in the first instance. The team wanted to explain with as much clarity as possible our view of the source of these symptoms, to emphasise the good outcome that we anticipated and, most importantly, to convey our opinion that Nam was not at risk of dying as a consequence of this illness. Symptoms were to be dealt with by a low dose of imipramine (building up to 100 mg at night), the pharmacological treatment of choice for panic attacks. A psychotherapeutic relationship with Nam was also developed, within which he was able to talk about the emotional effects of his current situation and, if he were able, his earlier life experiences.

The formulation was an elaboration of a psychiatric model that assumes the presence of an unconscious mind, relying on the distinctively Western concept of the person in which inner mental life and childhood development are given priority. The core assumption underpinning this formulation is that childhood memories are laid down in the unconscious mind, one after another, and are

reactivated in adult life causing emotional problems. The stressor causing the reactivation is thus an analogue of the initial trauma. This model has its own characteristic idioms: "stress" and "traumatic experience". Although physical symptoms may be a starting point, they are only 'surface phenomena'. The objective therefore is to look "inward" and account for these symptoms in terms of inner, more fundamental, mental events and mechanisms. The model may be visualised as a causal equation – with an arrow going from the psychological to the somatic, the deep to the superficial, the inner to the outer, the past to the present. Anxiety is thus shown to lead to physical symptoms. Whereas medication is used to treat the surface symptoms (somatic), psychotherapy is used to rectify the underlying cause(s) – the psychological symptoms.

In contrast, Nam's model also takes the body and its symptoms as a starting point but it does not look inward into the mind or backward in time to account for them. Nam found his explanations at the interface between his bodily self and his physical, spiritual and interpersonal environment. He couched his explanation firstly in terms of the passage of morally charged substances across this interface – wind, with its oblique implication of evil spirits, invading his body; vital semen and life energy being drained out. Secondly, his explanation was couched in terms of his sexual relationship with his wife. He built a picture of himself as a man whose vitality had ebbed away, to leave him depleted in emotion and spirit and vulnerable to dangerous sexuality.

Clinical presentations of this type are frequently interpreted as examples of somatisation: translating unacceptable mental and emotional experiences into acceptable physical symptoms with consequent primary and secondary gains. These gains being the containment of anxiety, and the eliciting of care, respectively. However, this approach merely feeds straight back into the Western psychosomatic model of the "psyche" as the deep source of fundamental causes in contrast to the "soma", regarded as the superficial locus of symptomatic expression.

Translation error is also a cause of misunderstanding. In some traditional cultures, bodily idioms are not necessarily somatic. As demonstrated here,

words that might sound somatic to the Western listener – weakness, semen, wind – are words that, to the Vietnamese ear, carry spiritual, emotional and interpersonal meanings. These latter meanings are as significant as the references to the physical body; indeed they are inseparable from them. While wind might sound physical, a careful translation points to the spiritual evil that it connotes; the loss of semen might seem as if it is merely a loss of seminal fluid, yet it also involves a depletion of vital energy; weakness too may be taken as a somatic problem only, yet weakness may extend into the spiritual and emotional sphere as well.

Instead of seeing this presentation as somatisation, it might be more accurate to view it as an example of "anti-mentalisation," in a culture where "mental" does not refer to the mind so much as to chronic psychosis or intellectual retardation. Nam was especially careful to distinguish his condition from mental illness, and quite emphatic that there was no history of mental illness in his family. He was not somatising in the Freudian sense; he was simply making the point, by use of bodily idioms, that he was not a "madman" or an "idiot" – an important point to establish when talking to a psychiatrist.

The team, coming from respective individual cultural beliefs and origins, engaged in a clinical relationship with a relatively successful outcome. Nam's body was the major point of correspondence between our respective models, across which a therapeutic bridge was constructed. Though Nam spoke about his body as if it were a field of interpersonal, emotional and spiritual meanings, and we spoke about it as if it were a field of superficial symptoms, we agreed that it needed to be treated. The concept of vulnerability was another commonality between our models. Nam expressed his vulnerability in terms of "weakness" arising from the bus trip home from the other city, whereas we viewed it in terms of death and loss, including the recent experience of his uncle's death and the earlier developmentally significant experiences of his childhood and adolescence. Vulnerability, nonetheless, provided a resonance between the different perspectives, enabling a meaningful discussion about his uncle and thence his father.

Nam eagerly accepted, and strictly adhered to the psychopharmacological treatment that was recommended. By the same token, it was concluded that coin scratching treatment should be continued if Nam thought it was indicated. Our encouragement of his brother-in-law in coming to the ward to carry out the scratching indicated to Nam and his family that we were not about to ridicule such treatment as magical or their explanations as superstitious. This is a common source of reticence among Southeast Asian immigrants to Australia when speaking to their doctors. Involvement of Nam's family thus played a significant role in the successful outcome of this case. The team's attitude of ethnographic curiosity and inquisitiveness (questioning what each term meant, attempting to record particular Vietnamese words phonetically) also conveyed to Nam our interest in and respect for his views. This was an interesting example of a well recognised phenomenon whereby a clinician's research interest can have therapeutic implications for the patient. It could be argued that the stark differences between our respective cultural definitions of the situation served as a therapeutic resource rather than a barrier. This, in turn, would suggest that one of the central effective components of therapy is the process whereby clinician and patient together build an intersubjective understanding of the illness and its treatment.

As an acerbic footnote: an antidote to the glow of cross-cultural communication – it should be noted that at no time did Nam ever appear to benefit from our attempts to discuss the death of his uncle, or the practical problems of raising three children with a mortgage and no regular employment, and further mention of the war was abandoned. He responded to such overtures with great puzzlement.

NOTES

1. The identity of the patient is obscured by use of pseudonyms and false place names. Because I was older than he and because I was his doctor, the patient preferred that I call him by his individual name rather than his family name. Accordingly I refer to him as "Nam" throughout this case report.

2. To ensure confidentiality this is also a pseudonym. I refer to Lê Van Tam in this case report as "Mr Lê", as I did during my clinical interactions with him and Nam.

3. I used the plural, "we" to designate our team: the psychiatric nurses, the social worker, the trainer psychiatrist, and myself, the psychiatrist.

CULTURAL COMPETENCE IN MENTAL HEALTH CARE

Developing cultural competence is a process, not an endpoint. The following checklist outlines the features of a culturally competent health practitioner.

A practitioner is culturally competent when they:

- Understand the concept of culture, and how it can influence human influences, including emotions generated by intercultural interactions.

- Demonstrate a willingness to explore the above from the perspective of people from CALD backgrounds.

- Demonstrate the ability to identify culturally appropriate strategies for working with people from CALD backgrounds.

(Fitzgerald et al., 1996).

Consider the following specific areas of cultural competence:

Acceptance of Diversity

- Are you open to cultural differences and different ways of doing things?

- Do you respect diverse practices and requests without judgement?

Equity and Access

- Do you recognise that clients require equality of care irrespective of their culture and linguistic background?

- Do you recognise, elicit and actively accommodate clients' choices about their care?

- Do you assume you know what a patient wants/needs?

- Are you aware of the sources of extra social support, community

organisations and resources available to CALD clients to overcome barriers, such as lack of English proficiency or support networks?

■ Do you facilitate your CALD client's access to the available resources and support?

Communication

■ Do you react adversely to a patient's accent?

■ Do you use simple language, avoiding technical terminology, abbreviations, professional jargon, colloquialisms, abstractions, idiomatic expressions, slang and metaphors?

■ Do you use an interpreter when interacting with a client from a CALD background whose proficiency in English is inadequate?

■ Are you aware that you could be legally liable if you do not organise an interpreter when necessary? It is advisable to cover yourself by making notes in the chart if the patient refuses to have an interpreter. The telephone interpreter service should be offered if an on-site interpreter is refused.

■ Do you encourage the interpreter to refrain from inserting his or her own ideas or interpretations, or omitting information?

■ Do you check the patient's understanding and the accuracy of the translation by asking him or her to repeat the message or instructions in his or her own words, facilitated by the interpreter?

■ During the interaction, do you look at and speak in the first person directly to the patient, not the interpreter?

■ Do you listen to the patient and notice nonverbal communication that indicates emotion associated with the topic?

Adapted from: Bertram and Laverty (1994); Fitzgerald et al (1998).

COMMUNICATING EFFECTIVELY

Adapted from: Allotey et al. (1998); Fitzgerald et al. (1996); Multicultural Access Unit (1999).

Interpersonal communication involves both verbal and nonverbal interaction. Nonverbal communication is as important as verbal communication. The following are some tips on communicating across cultures.

Explain your role to the patient:

For those from countries that do not have equivalent professions, it is a vital first step in communication to ensure the client understands your role. It is important to explain it to them simply and clearly.

Understand rules of communication:

Unspoken rules for communication are present in all cultures. They come from cultural models for interacting and are the basis for the assumptions people make about what can and ought to be said, about what and to whom, and in which situations. Pitch of voice, rhythm of speech, the emphasis placed on words and the actual words used in verbal communications are all subject to the principles and conventions of a cultural group.

Be aware that people express emotions in many ways:

Culture influences which emotions it is appropriate to express and how, when and where they should be expressed. The vocabulary for emotions and feelings varies greatly across cultures. Some cultures have a large and rich vocabulary to represent subtle differences. Other cultures seem to have few words to express and describe emotional feelings and states. In these cases, the few words available may take on different meanings depending on the context in which they are used and the ways they are used. All words for emotions lose something

when they are translated from one language to another. Emotions are also communicated in other ways. They can be expressed in words and silences, in the tone and volume of the voice, and via body language. Most emotional cues are subject to cultural interpretation – and misinterpretation.

Do not assume English proficiency:

Information is subject to misinterpretation, even if a person speaks English fluently. Words and sentences are structured differently in different languages. Be aware that if a person speaks two languages, they may transfer structural or grammatical elements from their first language to the second language. This often happens when a person gets excited or distressed.

Note differences in meanings of words:

Some words or phrases have different meanings in different cultures. Most Anglo-Australians use "yes" as an affirmative, but in some cultures "yes" can be a form of acknowledgment rather than an indication of agreement. Eliciting responses such as "I understand" or "that is correct" may be helpful.

Do not make assumptions about a patient's level of understanding:

Making assumptions about poor levels of comprehension and skill can result in a client feeling patronised if they have some knowledge of English, medical terminology or hospital practice.

Respect beliefs and attitudes:

People have different reactions toward illness and mental health. These are built up over a lifetime, and cannot be dismissed without creating a barrier in the communication process. It can help if you ask the client to provide you with information about their own ideas. For newly arrived immigrants, asking a client "Could you tell me what would happen to you if you were in your former country?" or "I don't have a great understanding of this" or "I am interested to know more" are ways to encourage intercultural dialogue, and by doing this, you are acknowledging to the client your awareness of, and interest in, his or her different perspective and experience.

Take the time to explore any issues:

Miscommunication or conflict can be resolved with patience, respect and extra time.

Speak clearly and slowly:

Communication is two way. It is important to ascertain that you understand the client and that the client understands you. Ask the client to let you know if they don't understand your accent, would like you to speak more slowly or would like clarification, eg. writing down words that are not clear. Avoid jargon, confusing phrases, double negatives and rhetorical questions. Be wary of sounding condescending.

Listen and observe:

Spoken communication is only one part of communication. Levels of eye contact, facial expressions, gestures, style of speaking, pronunciation, rate and volume of speech, the complexity or simplicity of the words we use, the emotional tone used to deliver them, the use of pauses, and the way we dress, are all ways of communicating messages non-verbally. Nonverbal communication assists in regulating turn-taking in conversations and ensures a smooth flow in the communication process. It has a function in regulating individual self-expression. Nonverbal cues to facilitate these functions are influenced by cultural norms, and may vary across cultural groups. Failure to recognise and respond to regulating cues may lead to misinterpretation, confusion and loss of respect.

Silence as a response may be used to convey messages, but silence can have many meanings. In cultures which are particularly concerned with maintaining harmonious relationships, silence may be used to convey disapproval or to indicate non-acceptance of a suggestion. In other societies, silence can indicate agreement or approval.

The way behaviours are used, the level of expansiveness of the behaviour and the degree to which the nonverbal behaviour dominates the communication can modify the communication. Be sensitive to body language and take cues from it

- for example, the use of the index finger to single out a person may be seen as an insult by members of some cultures; maintaining eye contact may be a sign of respect in some cultures, but avoiding eye contact may be a sign of respect in others; smiling may be a sign of agreement for some, of apprehension for others.

USING INTERPRETERS

Adapted from: Translating and Interpreting Service et al.; Allotey et al. (1998)

Interpreters are an important resource in providing a voice for clients whose proficiency in English is poor or insufficient for the situation.

Using professional interpreters

It is essential to use professional interpreters.

■ Do not use family members or non-professional interpreters. You could be legally liable if you do. While it may be necessary in emergency situations to use family members, it is important to use professionals wherever possible.

■ Face-to-face interpreting or telephone interpreting may be appropriate to use in mental health care with CALD clients.

The interpreter's role

■ The purpose of interpreting is to convey the message from one person to another as accurately as possible. The interpreter is not supposed to analyse the information, or decide what should or should not be conveyed.

■ Do not expect the interpreter to be a cultural expert, or to calm the person down. They are simply there to repeat what you and the patient say to each other in a language that you can both understand.

> *As a general guide, a patient who has been in an English-speaking country for less than two years will need an interpreter.*

When using interpreters:

■ It is very important to find out which language and dialect is appropriate. For example, Taiwanese people sometimes get confused by the terms the

interpreter uses if the interpreter is from China, Hong Kong, or Malaysia.

■ It is important to note the ethnicity of the interpreter. Some clients may not want to have interpreters from specific communities, for political reasons or because of confidentiality fears in small communities. For example, it may be inappropriate to provide a Serbian interpreter for a Bosnian Muslim.

■ It is important for most people to engage an interpreter of the same gender as the patient. If this is not possible, ask the patient if they are willing to accept the opposite gender before engaging an interpreter.

■ Use simple language, try to avoid using technical terminology, professional jargon, colloquialisms, slang and metaphors.

■ During the interaction, look at and speak directly to the patient, not the interpreter.

In mental health interpreting, the following points should be remembered:

The following are the responsibility of the health professional, not the interpreter:

■ When booking the interpreter, inform the interpreting agency if there are especially sensitive matters, which may be raised during the interview. Pre-brief the interpreter if required.

■ Maintain responsibility for the care of the patient.

■ Explain to the patient, through the interpreter, why the interpreter is present, and that confidentiality is assured.

■ Try to minimise interpreter-patient interaction before and after the interview if possible.

■ Shield the interpreter from any threatening behaviour if necessary.

■ If needed, and possible, counsel the interpreter after an interview that has dealt with particularly distressing events or circumstances.

■ Control the course of the interview, including lengthy speech segments that may be difficult to interpret.

■ Involve the patient, through the interpreter, in discussion of cultural issues, or discuss these with the appropriate multicultural health unit.

■ Respect the interpreter as a fellow professional.

Be aware of the following important guidelines:

■ **The patient's speech rate:** The interpreter should reproduce or approximate the patient's rate of speech, as this may be an important diagnostic clue.

■ **Rambling or circumlocutory speech:** If the health professional is aware of this tendency, it may be helpful to agree on a technique to cope. Otherwise, the interpreter may need to summarise the patient's speech, and inform the health professional what is being done and why. If possible, the interpreter should provide interpreted sample passages of the patient's discourse.

■ The interpreter should not interrupt a client's outburst of speech with a strong emotional content. If, as a consequence, full and accurate interpreting is not possible, a summary and examples of the content of the speech should be provided, and the health professional told of this.

To book an interpreter: Telephone: 13 14 50

ACCESSING SPECIALIST SERVICE PROVIDERS AND FURTHER RESOURCES

There are a number of agencies (eg., the state based Transcutural Mental Health Centres) which can act as cultural informants. These Centres have access to cultural knowledge and information from a variety of sources. If they do not have the information needed, they can recommend people or agencies able to provide the information.

There may be occasions where you feel that the cultural issues involved in the management of a case require more specialised services. Assisting people who have survived torture and trauma requires special knowledge and skills. It may be appropriate to refer such clients to specialists. In these situations there are national organisations who can provide information, as well as specialist agencies in most States and Territories in Australia to which a referral may be made. Many of these agencies also publish, on a regular basis, directories which are relevant to services for people from CALD backgrounds, or have a range of translated resource material.

National Organisations

Multicultural Mental Health Australia	02 9840 3333
National Ethnic Disability Alliance	02 9687 8933
National Forum of Services for Survivors of Torture & Trauma	02 9794 1900
Commonwealth Dept. of Health and Ageing	1800 020 103

ACT

ACT Transcultural Mental Health Network	02 6207 6279
ACT Multicultural Council	02 6249 8994
Companion House	02 6247 7227

NSW

NSW Transcultural Mental Health Centre	02 9840 3800
Multicultural Disability Advocacy Association	02 9891 6400
STARTTS	02 9794 1900

Northern Territory

Mental Health Services, NT	08 8999 4988
Multicultural Community Services of Central Australia	08 8952 8776
Melaleuca Refugee Centre	08 8985 3311

Queensland

QLD Transcultural Mental Health Centre	07 3240 2833
AMPARO Advocacy for NESB people with a disability	07 3394 9304
QPASTT	07 3844 3440

SA

Multicultural Mental Health Access Program	08 8243 5613
Dept. of Human Services, SA	08 8226 8800
MALSSA	08 8244 7777
STTARS	08 8346 5433

Tasmania

Dept. of Health & Human Services, TAS	03 6233 3185
PHOENIX	03 6234 9138

Victoria

Victorian Transcultural Psychiatry Unit	03 9417 4300
Action on Disability within Ethnic Communities	03 9383 5566
Victorian Foundation for Survivors of Torture & Trauma	03 9388 0022

WA

WA Transcultural Mental Health Centre	08 9224 1760
Ethnic Disability Advocacy Centre	08 9338 7455
ASeTTS	08 9227 2700
Multicultural Access Unit	08 9400 9511

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