PSYCHIATRIC DISORDERS IN A TRANSCULTURAL SETTING

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Abstract

Cultural competences are emerging as necessary psychiatric abilities as far as the demographic context of North America and Europe is rapidly and intensely changing, and the causes and outcomes of major psychiatric disorders are deeply influenced by cultural factors. Consistently, the understanding of the ethnic and cultural different backgrounds of psychiatric patients carries relevant clinical implications. The aim of the present paper is to offer the clinicians an overview of the field and to give some practical suggestions. Addressing the clinical aspects of caring for patients with a different ethno cultural origin may also lead to reflect upon our own Western culture. For a more complete overview of the different reviews, I referred to previously published papers. I reviewed 207 English written articles addressing this topic. I then summarized the most significant clinical aspects from both psychiatric and anthropological perspectives.

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The demography of North America and Europe is changing so rapidly and intensely that about half of the U.S. population will be estimated to be of minority background within the period of another 50 years (US Bureau of the Census 1998; American Psychiatric Association 2002). Moreover, the newcomers' acculturation is open to debate. It has been assumed that the majority of the newcomers, with non European origins, would gradually become just like all other Americans and Europeans through a process of cultural assimilation (Portes and Rumbaut 1996, Susser and Patterson 2001). However, sociological research has shown a high degree of retention of ethnic culture. Some studies made at the Mount Sinai Hospital of Toronto showed a very low level of acculturation in majority of the patients from ethnic minorities who were in treatment there for mental health diseases. They were mostly Asians (80%) and 32% of them were illiterate in English or French, 55% were so unfamiliar with the mainstream culture that they were unable to perform basic tasks such as setting up telephone or bank services, find housing or to maintain any social contact within the mainstream society (Yang 2005). Indeed, social and cultural factors are yet major determinants addressing the use of health care services and alternative source of help (Rogler and Cortes 1993).

Being the social paradigm one of the ruling dimension of Psychiatry, it is rational to think that these changes will deeply influence the theory and practice of this medical branch. In fact, major psychiatric disorders are influenced by cultural factors (Kleinman 1988, Kirmayer 2001, Lopez 2000), and, consistently, current standardized epidemiological surveys reported wide prevalence variations of many psychiatric disorders across geographic regions and ethno cultural groups (Canino 1998, Kirmayer and Groleau 2001). These lines of evidence have been achieved by the most relevant psychiatric diagnostic manuals (DSM-IV and ICD 10) which identify the "culture" as one of the main diagnosis influencing factors (Lu 1995): this was meant also to avoid the "category fallacy" bias, which refers to using a classification scheme developed for one culture and applying it inappropriately to another where there is no relevance and no equivalent meaning (Kleinman 1988, Guarnaccia et al. 1990).

In Appendix I of DSM-IV-TR (American Psychiatric Association 2002) the clinician will find:

1) The Cultural Formulation, which it's recommended to address cultural aspect in every clinical relationship, not only with patients that come from a different ethno cultural background (see Table 1).

2) A glossary of culture-related syndromes, that DSM-IV-TR defines as "recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category" (American Psychiatric Association 2002).

1) The cultural formulation

Aiming to make culture more central in the DSM-IV, the devoted Task Force decided to operationalize a

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method that, even if standardized, still allowed for an individualized assessment of cultural factors in order to avoid stereotyping. After the outline of the Cultural Formulation was prepared, a field test was performed on patients from four US ethnic minorities: African American, American Indian, Asian American, and Latino. The results revealed that the CF model could be successfully applied to patients from different cultural backgrounds (Mezzich et al. 1995, Alarcon 1995). After its publication in DSM-IV, the CF has begun to form part of the curricula of US psychiatry residency programs and being the subject of a regular section on clinical case studies since 1996. In 2001, the Cultural Psychiatry Committee of the Group for the Advancement of Psychiatry published a book on the CF model that includes a number of case examples (Committee on Cultural Psychiatry, Group for the Advancement of Psychiatry 2001). The CF model supplements the biopsychosocial approach by highlighting the effect of culture on the patient's symptomatology, explanatory models of illness, help-seeking preferences, and outcome expectations (Lewis-Fernandez 1996, Lu 1995). In fact, patients that have a different cultural background often express distress and psychopathologies that are less in accord with the US diagnostic categories rather than with their popular syndromes. Finally, translation form popular to professional nosologies is often complicated. Even if applied in homogeneous ethnic groups of patients, CF can still elicit very useful information about culturally based values, norms, and behaviours such as: views on alternative health practices, physiological interpretations, or religious beliefs (Abas et al. 1998).

1.1 Cultural Identity of the individual

The section on Cultural Identity serves as an introduction for the rest of the Cultural Formulation. Its purpose is to identify for each patient the particular mix of socio-cultural influences that has patterned his/her individual cultural world (Committee on Cultural Psychiatry, Group for the Advancement of Psychiatry 2001). In this section it is important to detect some central aspects of the patients' culture such as religion and mother tongue as well as other spoken languages during one person's infancy. Investigation of childhood development in a particular cultural context is also a relevant topic. For example, it may be not satisfactory to say that there are cultural clashes between mainstream and original cultures, as the identity issues are broad and nuanced: some of the determinants which might aid to better focus this topic are the age at time of immigration, the loss or gain of social status, level of education, intergenerational conflict in the home and gender roles (expectations and cultural values regarding marriage, divorce, and child-bearing). The effects of covert or overt racism and discrimination against ethnic minorities, added to the stigma of mental illness, are significant barriers to recovery also .

Moreover, once individual's ethnic or cultural reference has been detected, it is important to investigate the involvement degree with both origin and host cultures. This would be useful in order to prevent overly general or stereotypical interpretations of cultural influence (Lu 1995). Of note, even persons sharing the same race or ethnicity can differ in their cultural backgrounds, as race and ethnic groups are culturally heterogeneous (Smedley 1999). This takes on particular significance in settings of rapid cultural change or ethnic conflict, or among migrants or persons of multicultural heritage because in a world of mass migration, identity is often very hybrid, multiple and fluid (Bibeau 1997). The clinician in this way may avoid mistakenly assuming that, as migrants adapt more to the culture of the host country, they necessarily become disconnected from their culture of origin (Rogler 1991). Contemporary acculturation models understand that, in a world where multiculturality and geographical displacement are becoming increasingly prevalent, multiple combinations of involvement in the two cultures are possible. There could also be the alternative of developing a deep connection to both cultural environments (Maryn 1996). The etnocultural and religious group which the patients most identifies with, may depend on who asks the question and in what context.

Acculturation

APA (2002) defined 4 different attitudes toward acculturation and cultural identity development:

1. Separation: desire of the individual, more or less conscious, to conserve his/her cultural integrity.

Clinical examples may be traditional families, born and raised in their country of origin, that in general speak their native language only, live in ethnic enclaves (like Chinatown or "Little Italy" in New York City), sharing a rural background. People of this kind might cope with problems by concrete manners, often describing their problems in somatic terms. This is possibly associated with adjustment and major depression disorders.

2. Integration: it derives from the ability to maintain the person's own cultural traditions.

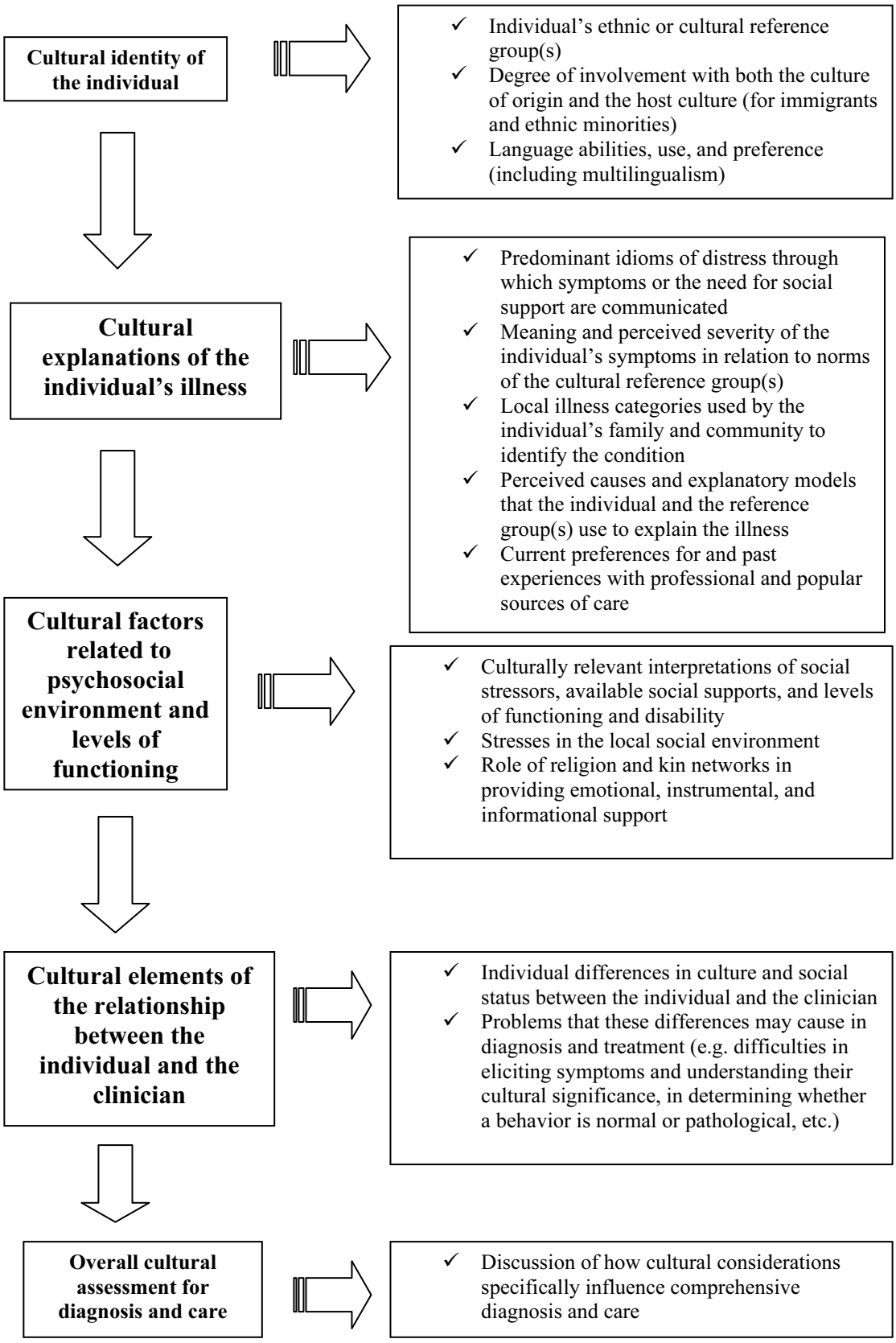
Incorporating values and norms belonging to the host culture, might lead to "bicultural" persons. A clinical example may be found in transitional families where the parents speak very little English, whereas their children are better acculturated. Parent-child conflicts, role confusion, and marital difficulties may be more frequent in that situation since traditional roles are inverted being the parents dependent on their children for linguistic and cultural translation. Cognitive and behavioural therapies are considered to be effective for these patients (Lu 1995).

3. Assimilation: conscious or unconscious renunciation to one's culture in favour of a nearly complete assumption of values and behavioural characteristics of the host cultural group.

4. Marginalization: progressive loss of the person's cultural patrimony, in a context where there is a hostile attitude on behalf of the host society toward a minority.

Well-researched schema of cultural identity development has focused on African Americans (Cross 1991), African Americans and whites (Helms 1990), Asian Americans (Sue and Sue 1990), and Hispanics (Bernal and Knight 1993).

Table 1. *DSM-IV-TR cultural formulation*



Language

Language identifies and codifies an individual's experience, which may not be translated readily from one language to another without distortion.

In some cases, culturally diverse patients speak more than one language: in that case it is relevant to assess what they consider their primary language. Usually this is the language first learned, although it may not be the language of their ethnic culture, but of their host culture. Generally, the primary language is the one in which they feel most comfortable expressing themselves (Lu 1995).

Language has profound effects on clinical encounters. The assessment of higher cognitive functions, complex emotions and experiential symptoms of pathology, they all depend on the clinician's access to the patient's language. This does not affect doctor-patient communication only, it also influences individuals' ability to be introspective. When people are forced to formulate their problems in a language in which they are not proficient, they may be less creative and effective as problem solvers (Kirmayer et al. 2003). Multilingual people experience the fact that each language favours certain modes of expression and ways of thinking, so they may report that they feel like a different person using other languages. Some aspects of the patient's history and experience can be less accessible in the clinical evaluation because the patient communicates in the second language, but it may also create distance from intense emotions and painful memories. Careful attention to spontaneous shifts in use of language in a multilingual assessment can provide the clinician with relevant information about areas of conflict and strengths (Del Castillo 1970, Marcos et al. 1973, Westermeyer 1989).

Different ethnic groups also communicate in different styles. For example, Sue and Sue (1990) stated that there are high content groups, such as African Americans, Asians, Hispanics, and Native Americans, who use different nonverbal communication than other ethnic groups, such as whites.

Religion

Religion is frequently neglected during routine psychiatric evaluation, despite the fact that it's a central key of one's identity one's identity, despite the ubiquity of religious and spiritual experience and the fact that it's sometimes the cause of experiences of discrimination. Religious beliefs may also have an impact on clinical aspects such as suicidal attempts (Dervic et al. 2004). Areas to cover include religious identity, the role of religion in the family of origin, current religious practices, motivation for religious behaviour and specific beliefs of individuals and of their family and community (Numbers and Amundsen 1986, Sullivan 1989).

1.2 Cultural explanations of the individual's illness

This subsection is devoted to a careful assessment of predominant idioms of distress, meaning and perceived severity of the individual's symptoms, local illness categories used, perceived causes and explanatory models of illness. Current preferences for and past experiences with different sources of care are assessed also.

It is essential that cultural norms be considered when assessing the clinical severity of specific behaviours, so as to avoid two erroneous extremes: overpathologizing what is normative in a cultural group, or ascribing to normal behavior what is considered pathological in that culture (Ortega et al. 2002, Ranz et al. 2000). The fact that different subgroups within a larger cultural setting may interpret these behaviours differently complicates the process of assessment and forces an individual evaluation of cultural factors in each case.

Perceived Causes and Explanatory Models

This subsection focuses on the patient's views on how the illness "works" (what it was caused by; why did it appear in that moment and way; how it is affecting the person; what would happen if it was not treated; and what are the possible outcomes after treatment?) (Cross 2002, Bhui 2007, Kleinman 1980). This subsection, like the next one on *help-seeking* to which it is closely linked, is especially important during the process of enlisting the patient's and the family's adherence to the clinician's recommendations. Empirical evidence suggests that patients are most satisfied where their psychiatrist shares their model of understanding distress and treatment (Callan & Littlewood 1998). Moreover, patients rarely pursue treatments for a long time, that run counter to their primary etiological understandings. Cultural attributions of causation actually vary widely across societies, from biological to spiritual etiologies, and from drastically individual, internal views to social and even cosmological interpretations (Marsella 1982). A study of first-time mental health services seeking persons showed that explanatory models do not consist of a coherent set of beliefs but of a variety of explanations, and that they are either held simultaneously or taken up and dismissed rapidly (Williams & Healy 2001). Treatment may thus involve negotiating the appearance of these various perspectives and bringing them into some coherent strategy (Kleinman 1988). Williams & Healy recommend the term 'explanatory map' rather than 'explanatory model', as this reflects the diversity and complexity found within systems of health beliefs. In many cases, particularly with acute illness, patients may have not well-developed models, relying on their own past experiences or on family, friends or mass media prototypes. Therefore, an open-ended interview might represent a correct incipit to obtain more complete information about the cognitive and social factors influencing the patient's illness. This may reveal idiosyncratic association that may not fit any explicit cultural model and that may be investigated by some questions about prototypes (Have you ever had anything like this before? Has anyone you know ever had anything like this before?). Finally, it is appropriate to

inquire into explicit cultural models using the sort of question devised for the explanatory model interview (Bhui and Bhugra 2002). Kleinman explanatory model was structured as follows:

- What do you call your problem?
- Does it have a name?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your illness do to you?
- How severe is it?
- How does it work?
- What results are you looking for? (Kleinman 1988).

Help-Seeking Experiences and Plans

Cultural and explanatory models of the patient's illness also affects help-seeking behavior. Adherence to clinicians' recommendations may be compromised without careful attention to patients' cultural views of treatment. Patients' help-seeking choices actually tend to follow "pathways" of care which are partly determined by psychosocial and cultural forces. Cultural perceptions and interpretations of illness not only affect how it will be expressed (somatically, behaviourally or emotionally) but also affect the decision of whether and when to seek formal care (as opposed to being self-reliant or asking for help from the immediate social network), and the type of treatment that is considered to be adequate and effective (Kleinman 1988, McGoldrick et al. 1982, (Rogler and Cortes 1993).

For example, some patients tend to act healthier than they are, in order to avoid the stigma of illness. A collateral history is then sometimes necessary to obtain an accurate picture of the case. On the other side, families and other informants may also minimize symptoms because regarding mental disorders there may be a stigma in seeking assistance that involves the family/community level. In this respect, it may also be necessary to account for the views of key relatives or members of the larger social network (McKinlay 1981). Many first-generation ethnic minority patients, such as recently immigrated Asians, expect their clinicians to be authoritarian, not egalitarian, and are confused by a non-directive stance (Schlesinger 1981).

As with etiological attributions, help-seeking pathways can also be quite complex, with multiple forms of care being accessed at once, or in apparently contradictory ways. Indigenous healing practices may be utilized: examples include curanderos, shamans, medicine men, and fortune tellers (Gaines 1991). For example, a typical sequence of coping and help seeking in a traditional Chinese family might include interfamilial coping, followed by consultation with trusted elders and friends. The family would then seek outside help, going to herbalists and acupuncturists (Lu et al. 1995). They might then consult a religious person, or a physician, but would present with somatic complaints. Finally, as the patient deteriorates, the family reaches its limit and can no longer maintain the patient at home. There often is a rejection and scapegoating of the patient to decrease the shame and humiliation to the patient's family. Hospitalization in a Western hospital may represent the last resort (Lin and Lin 1981).

1.3 Cultural factors related to psychosocial environment and levels of functioning

Migrant and ethnic minorities in Western countries are frequently compounded by stressors socioeconomic disadvantages, social isolation, legal entanglements, inadequate housing, racial discrimination, and heightened stigma against mental illness in their families and local communities. Ethnic minorities are known to have even higher rates of homelessness, emergency room visits, hospitalizations, and legal involvement than the highly disadvantaged general population with SPMI (Dein 2007, Law et al. 2003). Loss of the family and community support network is critical because research has suggested that family and social support is associated with favourable outcomes in developing countries (Yang et al. 2005). Another important issue is the one regarding a strong association between undocumented status and poorer mental health outcome. In this population higher rates of hospitalization and rehospitalization, lower treatment compliance and insight into illness has been found, together with many social disadvantages (Law et al. 2003)

It seems important to clarify how these topics interact with the clinical situation of the patient. In particular for recently immigrated patients, an important part of their cultural identity relates to their migration history, which should be recorded in the psychosocial history section of the written evaluation. As described by Lee (1990) (see Table 2), the purpose of a migration history is to determine the patient's background history and to measure their baseline functional level as well as the generational status of the patient.

Table 2. *Migration history*

- Premigration history: Country of origin, family, education, socioeconomic status, community and family support, political issues, war, trauma.
- Experience of migration: Migrant versus refugee: Why did they leave? Who was left behind? Who paid for their trip? Means of escape, trauma.
- Degree of loss: Loss of family members, relatives, friends. Material losses: business, careers, properties. Loss of cultural milieu, community, religious, spiritual support.
- Traumatic experience: Physical: Torture, rape, starvation, imprisonment. Psychological: Rage, depression, guilt, grief; posttraumatic stress disorder.
- Work and financial history: Original line of work, current occupation, socioeconomic status.
- Support systems: Community support, religion, family.
- Medical history: Beliefs in herbal medicine, somatic complaints.
- Family's concept of illness: What do family members think the problem is? Its cause? What do they do for help? What result is expected?
- Level of acculturation: First or second generation.

- Impact on development: Level of adjustment, assess developmental tasks.

Source. Adapted from Lee 1990.

1.4 Cultural Elements of the Clinician–Patient Relationship

This section allows the clinician to consider how his/her own role or institutional setting has affected the patient's experience with the illness, including symptom expression and treatment response. "We don't know who discover water but it wasn't the fish". The same can be said about culture: we are immersed in our own cultural worlds from birth and consequently our culture is largely implicit and unexamined (Kirmayer et al. 2003). The scientific emphases on objectivity and reality sometimes causes psychiatrists to mistake their activity for that of invisible observers, who exert little effect on the situation observed. On the contrary, much clinical and ethnographic research has described how patients' symptom descriptions and etiological attributions are shaped across health care settings in response to clinicians' verbal and nonverbal elicitations and to individual and collective expectations of what the purpose and the norms are for each kind of setting (Rogler 1993).

Clinicians also need to be aware of their attitudes toward their patient's particular ethnicity to assist in engaging and understanding the patient (Spiegel 1976). The American Psychiatric Association's position statement (1993) on bias-related incidents noted that bias-related incidents, arising from racism, from sexism, from intolerance based on religion, ethnicity and anti-gay prejudice, are widespread in society and continue to be a source of social disruption, individual suffering, and trauma.

Hughes (1993) described methods for clinicians to attain self-knowledge; he suggested that clinicians might be better to first examine their own assumptions about their patients, on the basis on their first impressions. Then, they should critically analyze signs they are using to define pathology (appearance, mannerisms, or behavior), and to look for stereotypes that may be influencing their judgment and behavior toward patients (Lu 1995).

Another way clinicians can assess their ability to work with culturally diverse individuals is to evaluate their own "cultural competence." Cultural competence can be defined as a set of culturally congruent beliefs, attitudes, and policies that make cross-cultural work possible (Cross et al. 1989). Cultural competence exists as points along a continuum, ranging from cultural destructiveness (e.g. racism), cultural incapacity (e.g. biased and lowered expectations of minority clients), cultural blindness (e.g. all people are the same), and precompetence (attempts to improve some aspect of the service in serving minority groups), to cultural competence, and finally, cultural proficiency (agencies and individuals who are adding to the knowledge based on culturally competent practice through research and other activities). The openness of the clinician's attitude is critical in avoiding bias in assessment and treatment. Clinicians must be willing to suspend judgment; accept new lifestyles; and approach ethnic minority patients with flexibility, warmth, understanding, and empathy (Lu 1995).

Transference and Counter transference

Comas-Diaz and Jacobsen (1991) explored how cultural, racial, and ethnic factors can arouse ethnocultural transference and countertransference both when the clinician and the patient are of different ethnic groups (interethnic) and when they share a common ethnicity (intraethnic). An example of interethnic transference can be seen in a Native American's distrust of an authoritarian figure from the dominant culture.

Ethnocultural countertransference can also be seen. An example of interethnic countertransference is the cultural anthropological syndrome, where the therapist may react to cultural differences by becoming an amateur anthropologist on an intrusive fact-finding mission, quite distinct from the relevant clinical concerns.

Interpreter, clinician and patient: the therapeutic triad

An interpreter or cultural broker is frequently necessary when the clinician and the patient don't share the same mother tongue. Lee (1987) and Westermeyer (1990) described the relationships among the interpreter, patient, and clinician as points in a triangle, calling it the "therapeutic triad".

An optimal interpreter is trained in the basic aspects of psychiatric assessment and care. In general, family members should not be used as interpreters unless absolutely necessary because they commonly may not translate everything that the patient says because of concerns of family privacy and shame or family dynamics (Westermeyer 1990). The clinician should face and speak to the patient directly, slowly and clearly, avoiding jargon and idioms, and sticking to one topic at a time. One should allow adequate time, almost double of what would ordinarily be needed without an interpreter (Westermeyer 1989). Before the interview, it is important to clarify the type of interpretation desired, be it word for word, a summary, or a cultural explanation, when the meaning of a patient's answer may be related to the patient's cultural identity. During the interview, while the interpreter is speaking, clinicians must pay attention to the nonverbal communication between the provider and the patient. Caution must be used in interpreting observations about nonverbal indicators and it may be helpful to reserve interpretation until a better sense of their meaning can be obtained, perhaps with the help of a cultural consultant (Budman et al. 1992, Westermeyer 1989).

1.5 Overall cultural assessment for diagnosis and care.

The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care (American Psychiatric Association 2002).

2) Idiom of distress, difference in symptom presentations and culture-related syndromes

There are many differences in symptoms and idioms of distress in different cultural groups that are influenced by folk mental health classification systems distinct from US psychiatric nosology. These mainly come from cultural practices, familiarity with health care systems and pathways to care (Good, Herrera et al. 1982; Kleinman 1988).

2.1 Anxiety disoders

Different rates of anxiety diagnosis

Economic deprivation, uncertainty, traumas and specific environmental distress may pay a predominant role in increasing rates of anxiety in specific ethnic minorities or migrants. In the Epidemiological Catchment Area (ECA) study significant differences in rates of anxiety disorders were found among ethnocultural groups (Eaton et al. 1991). In the Los Angeles ECA site Mexican Americans had higher rates of GAD, simple phobia and agoraphobia than white people, when born in the US, and lower when born in Mexico. At Baltimore and St. Louis ECA sites African Americans were found to have higher rates of phobias even when sociodemographic characteristics were controlled (Brown et al. 1990). There is as yet little evidence to interpret these findings, even if they seem associated with a change in life-style and environment. Symptoms of PTSD are common in many refugee groups (Kinzie et al. 1990), and this must better be understood in a broad way, remembering that they doesn't simply escape from horrors, but also must face the continuing loss of family, community and traditions (Kirmayer 1995).

Idioms of distress

Cultural idiom of distress that fit, in DSM-IV-TR classification, with anxiety disorders, however may have different meanings:

1) They may occur at lower levels of individual psychopathology, as sub clinical idioms of distress, or they may not be perceived as pathological at all. For example when cultures, like a Haitian one, reinforce dissociative experiences through religious and healing rites or view them as a model to express anxiety, patients can show atypical symptoms, that may be mistaken as psychotic. Sensation of worms crawling in the head are common and non specific symptoms, in people from equatorial Africa, that may be present in GAD and panic disorders, as well as other psychiatric disorders, and are not pathognomonic of psychosis (Awaritefe 1988, Ebigbo 1986, Makanjuola 1987).

Another example is that whereas agoraphobia is common in US, (sample of phobic patients in Qatar), only 8% of women received this diagnosis. Wrote El-Islam "being bound to the home, which is a sign of agoraphobia in the West, is a sign of virtue in a Muslim housewife" (el-Islam 1994). This cultural differences could be misinterpreted by a clinician who is unaware of local mores.

2) They may be less stigmatized or have sociocultural meanings, which may contribute to a better prognosis. Nervios (Mexican-American), nevra (Greek), and other syndromes of "nerves" are common as somatized forms of anxiety and depression (Mollica 1987, Mesquita and Frijda 1992). Ataque de nervios is a Latino syndrome characterized by paroxysms of intense emotion, acute anxiety symptoms, and loss of control, often associated with dissociative experiences and occasionally with other/self-directed aggressive behaviours (Brown et al. 1990). Usually they follow immediately a stressful event and is considered as a normal reaction to it (Guarnaccia et al. 1993). It's the second most prevalent psychopathological syndrome in Puerto Rico and has a complex relationship with its psychiatric diagnoses, cutting across mood, somatoform, anxiety and dissociative disorders and in individuals with impulse control, somatoform, or psychotic disorders. The term nervios is used with a big range of meanings, from subclinical idioms to express distress up to psychosis. This has been found to avoid stigmatization, especially on regard to the most severe cases.

3) They may be harder to treat precisely because they don't seem "excessive and unreasonable" to the sufferer, because they are consonant with cultural values.

A Japanese form of social phobia, tajin kyofusho (Kirmayer 1991) has, as core symptoms, the fear to offend or making others uncomfortable through inappropriate social behaviour and self-presentation. Some Japanese psychiatrist group put together all variants of TKS, which include SP, delusional body dysmorphic and avoidant personality disorders (Tseng et al. 1992). This symptomatic presentation fits well with Japanese preoccupation with the proper presentation of self in the society, that is very tied to tradition and hierarchic ideals. It has been suggested that there is an increased in public self-consciousness, which has been shown to contribute to social anxiety (Schlenker and Leary 1982). This could also be tied to child-rearing, which encourages dependence and is viewed as a positive value that binds people together in mutually satisfying hierarchical relationships. Shoma Morita (Reynolds 1976) developed an indigenous form of psychotherapy based on a mechanism of vicious cycles of excessive self awareness, consistent with contemporary cognitive models, that clinical reports suggest to be effective even for delusional cases (Kirmayer 1995).

Another example is Muslim religious practice of warding off blasphemous thoughts through repetition of phrases, fears of contamination and frequent ritual to avoid pollution and cleanse the self (Okasha et al. 1994). These cultural practices can be very similar to OCD symptomatology and can also contribute to low rates of insight in these kind of patients if they became abnormal and pathological. Another example related to the belief of reincarnation present in Asia and Middle-East. A child who fears the water may claim that in

earlier incarnation drowned in a stream (Daie et al. 1992).

Idioms of distress

It's important to understand the meaning of local idioms of distress. Often they have deep connections with cultural and social environments. Here are some examples:

1) In the United States the Korean "syndrome" hwa-byung is found predominantly among lower socioeconomic levels, especially in married Korean women immigrants after middle age. Common symptoms include feelings of heaviness, burning or mass in the epigastric region, headaches, muscular aches and pains, dry mouth, insomnia, palpitations, and indigestion. But hwa-byung also includes depressive symptoms (sadness, negative thinking, loss of interest, feelings of regret, guilt, and suicidal ideas), anxiety, irritability, tendency to lose one's temper, and absentmindedness. More accurately, hwa-byung is not a discrete syndrome but an illness attribution in which symptoms are understood by sufferers to be due to the suppression of feelings of anger and resentment that form a sort of mass in the chest (Kim 1993, Lin 1992, Lin 1983, Pang 1990). Korean psychiatrists relate hwa-byung to the culturally distinctive sociomoral sentiment of haan—accumulated anger, resentment, and despair

Table 3. *Idioms of distress of depression*

Area of population	Idiom	Reference
American Indian	loneliness	O'Nell 1996
China	shenjing shuairuo (nervousness weakness)	Kleinman 1985, Lee 1998
India	sinking heart, feeling hot, Gas, semen loss	Bhugra and Mastrogianni 2004, Mumford 1999, Raguram et al. 1996
Iran	heavy heart, heat distress, chest tightness	Good et al. 1985, el-Islam 1994
Japan	futeishuso (non specific symtoms, e.g. shoulder pain); shinkei suijaku (neurastenia) jibyo (personal illness)	Kirmayer 2002, Lock 1993
Korea	hwa-byung (fire illness)	Lin et al. 1992, Pang 1990
Latin America	nervios (nerves)	Jenkins and Cofresi 1998, Low 1994, Guarnaccia et al 1990, 1993
Nigeria	heat in the head, peppery feeling in heat, heaviness in the head	Egibo 1986, Oheari and Odejide 1994, al-Issa 1995, Guinness 1992
Trinidad	tabanka (reactive depression)	Littlewood 1985
US, Canada, France	burnout	Ehrenberg 1998
Vietnam	wild illness phong tap (rheumatism) uat u'c (indignation)	Eisenbruch 1983, Grouleau and Kirmayer 2004

at historical, collective, and individual injustice. Patients can usually readily identify interpersonal and social problems that give rise to the anger, suppression of which then leads to physical illness.

2) In Nigeria, brain fag is a common syndrome involving sensations of heaviness, or heat in the head associated with the effort of studying. It may occur in conjunction with major depression, anxiety disorders, or adjustment disorders (Prince 1960, Guinness 1992, Jegede 1983, Morakinyo 1980). Typically, it has been reported among students who are the first in their families to become literate and who, in the process, have experienced both geographical and psychological separation from their families and community of origin: the distress they feel is maybe part of a larger social predicament they face.

3) Koro is a syndrome, that usually is epidemic, in which there's an acute and intense fear that the penis, for males (or less frequently, the breast for women) is shrinking into the body and causes death of the person (Bernstein and Gaw 1990). Since it occurs in minorities in the East and South Asia, it has been suggested that it may be a symbolic expression of the fear of extinction.

2.2 Depression

Different rates of diagnosis of depression

The WHO Cross-National Study of Mental Disorders in Primary Care found that the prevalence of major depression, evaluated in 14 different countries, varied 15-fold across centers (Ustun and Sartorius 1995), with the Asian countries showing the lowest rates. At higher- prevalence depression was associated with lower levels of disability and this may account for the variation of prevalence.

Differences in symptomatic presentation

There have been several efforts to develop culturally sensitive measures of depression and related forms of demoralization or emotional distress, (Kinzel 1982, Beiser and Fleming 1986, Mollica et al. 1987, Mumford et al. 1991, El-Rufaie et al. 1997, Patel et al. 1997, Abas et al. 1998, Phan et al. 2004) (see Table 3).

A previous WHO Collaborative study on the Assessment of Depressive Disorders compared patients seeking help at clinics in cities like Canada, Switzerland, Iran and Japan with a standardized interview instrument. The most common symptoms across sites were sadness, joylessness, anxiety, tension, lack of energy. Feeling of guilt and self-reproach varied across sites: 68% in Switzerland, 58% in Canada; 48- 41% in Japan; 32% in Iran. Around the world a common way to describe experiences associated with depression are expressions that mention a soul or spirit loss (Kirmayer and Jarvis 2006). This can occur in many different ways and the cause may be found in social or other salient events. Many people in Central and South America for example attribute to an intense acute fright (susto, espanto, pasmo) a sudden flight of the soul, that is more linked to depression rather than anxiety (Okasha 1994)

An individual's awareness of dysphoria and difficult social circumstances may coexist with a reluctance to express depressed mood and to explicit point of social conflict, particularly in societies influenced by cultural values of social harmony, hierarchy and equilibrium. Southeast Asiatic patients, for example, are more likely to consider somatic symptoms rather than depressive feelings as legitimate reasons for consulting a physician. Affective expression of depression may be perceived as self-centred, asocial and threatening the social structure (Yen et al. 2000). According to Confucianism the cultural concept of the person, is based on the social and communal embedding of the individual, who is rarely conceived of as a free-standing unit (Kirmayer and Jarvis 2006). Hence, containment of emotion and adaptation to social circumstances are viewed as signs of maturity (Wikan 1990). A consequence of this may be that samples of depressed Southeast Asians in clinics may be composed of that subgroup of depressed patients in the community who suffer concurrently from prominent somatic symptoms.

In a critique of the assumption of universality, it's possible to argue what is identified as depression derives from larger sociomoral and religious frames, which differ across culture. Some of what is considered pathological in depression (e.g., denigration of the self and the body) may be given a positive value in the content of a Buddhist society that seeks to understand the illusory side of the self. Psychological research in the US suggest that healthy people have a self-enhancing bias(Asendorpf and Ostendorf 1998). This appears to be one way to maintain a strong sense of an independent self (Kitayama et al. 1997). People who are depressed are less likely to show self-enhancement (Lewinsohn et al. 1980). Cross cultural research shows that people from many Asian countries are less prone to self-enhancement and, instead, tend to be self-critical (Heine et al. 2001). For example this is considered a part of a socially shaped process of self-improvement in Japan (Heine et al. 1999). Anyway, as seen from the WHO study, they seem to have lower rates of depression. This seems linked to their focus on social and cultural ideals of harmony (Kitayama 1997, Shweder et al. 1997).

The last example about different meanings for psychiatric terms is about the Amish definitions of grandiose. In this very traditional culture it is described as a behaviour within the host culture's norms of behaviour, such as driving a car or planning a vacation during the "wrong season," yet exceeded their norms sufficiently to meet criteria for bipolar disorder, because they were Amish (Lu 1995).

Therapy

In treating patients it's important to remember that exaggerating the individual-centeredness of emotional conflict and its resolution and fostering individualism through psychotherapy may put people from more socio-oriented cultures, as Southeast Asia, more at odds with their families and local worlds and some of the

undermine both social support and their own sense of self-worth (Kirmayer 1989). Several studies have found a very low rates of treatment compliance among Southeast Asian patients in the US (Kinzie et al. 1987, Kroll et al. 1990). Nilchaikovit et al. (1993) noticed that some differences in the therapeutic relationship between American and some Asian countries. In the US it is emphasized as egualitarian and based on contractualism whereas in Asia it's more gerarchic and the patient is expected not to make comments about the authority and recommendations of the physician. In this way there's the risk that they will not openly disagree with a treatment for the fear to offend the physician, but then, when blood level of medication is screened, they are usually found as non compliant (Kirmayer 2001).

Although antidepressant medications are broadly effective, significant variations in pharmacokinetic and pharmacodynamic across ethnocultural groups are well documented (Lin 2001, Roy-Byrne et al. 2005). Hence, clinicians must monitor and adjust levels carefully, attend closely to side effects and watch for potential interactions with commonly used herbal remedies and dietary practices. It may be possible to use some traditional therapies, that sometimes may be not so far from Western cognitive ones. A current popular mode of psychotherapy for depression-mindfulness training-is based on Buddhist concept of mental functioning and meditative practice. Interventions focus on modifying habitual patterns of thinking as a means of preventing responses likely to maintain depression or contribute to relapse (Teasdale et al. 2000).

2.3 Somatization

Different rates and different meanings of somatic symptoms

Although somatization is often thought to be characteristic for specific ethno cultural groups, some recent evidence suggests that somatization is ubiquitous and somatic symptoms are the most common clinical expression of emotional distress worldwide (Kirmayer and Young 1998, 2001). Differences among groups may reflect cultural styles of expressing distress (idiom of distress) that are influenced not only by cultural beliefs and practices but also by familiarity with health care system and pathway to care. The notion that somatization is more common among or characteristic of patients from certain non-Western cultures, particularly Asians and Africans, has become well entrenched (Weiss 1995).

Fabrega (1991) has pointed out that in most of the great traditions of medicine (e.g., Ayurveda, Chinese medicine), a sharp ontological distinction between the "mental" and the "physical" did not occur. In the case of Traditional Chinese medicine, Author argues that there was no ontological notion of disease at all; medicine was based on symptom clusters or syndromes that reflected imbalances in bodily systems that can be also related to aspects of larger social and ecological systems. Tseng (2001) argues that Asiatic patients usually express their mental suffering using terms coherent with Traditional Chinese Medicine like 'kidneys weakness' (psycho-sexual problems), 'bodily and liver fire' (anger or anxiety), 'soul loss' (depression or dissociative states).

In a seminal study, Good (1977) showed how the idiom of "heart distress" among Iranians, and in general in the Middle-East, can be understood as a culturally prescribed way of talking about a host of personal and social concerns primarily related to loss and grief, not just as potential signs of illness. Similar metaphors grounded in bodily sensations and ethno physiological notions are found in the complaints of chest tightness among Turkish women (Mirdal 1985) and the corresponding Greek symptom of stenohoria. Also notions of blood as central to health are found among many peoples and may tie together diverse symptoms in networks of meaning that map both hygienic and sociomoral notions (Laguerre 1987, Sobo 1993).

As seen before, culture-related syndromes have predominately somatic symptoms that in most cases coexist with and are attributed to emotional and psychosocial distress (e.g., bilis or colera, hwa-byung, brain fag, dhat, shenkui, falling out, koro, shenjing shuairuo, and neurasthenia) (Kirmayer 1998). Serious consideration of cross-cultural variation lead DSM Task Force to define cultural-related syndromes, because they are better understood as disorders in their own right, that do not fit with any of the broader categories of somatoform, affective, or anxiety disorders. Thus, neither brain fag

nor dhat can be viewed simply as somatized forms of depression or anxiety (Mumford 1996). The syndromes have their own etiological, prognostic, and therapeutic implications and their own social course. Somatic symptoms may function as social moves or "positioning" whether or not the individual is aware of this process. The clearest examples of this are reported among oppressed minorities: the victims of exploitation and humiliation, based on gender, race, ethnicity, and economic disadvantage (Lock 1993, Lewis 1971). In this case, certain symptoms have been interpreted as being forms of "resistance" or "weapons of the weak," used to evade or attenuate injustices or to undermine otherwise unassailable power holders (Lock 1993, Comaroff 1985). Compared with frank complaints about one's psychological state or social situation, however, somatic symptoms are oblique or indirect and, hence, may protect the powerless from the counter-attack that might be elicited by more direct criticism (Kleinman 1986).

Therapy

In South Asia, a great variety of physical and psychological symptoms may be attributed to loss of vital essence through semen. In India, this takes the form of the dhat syndrome (Paris 1992, Bhatia 1991). As evidence of semen loss, patients may report turbid urine or express concern about nocturnal emissions or masturbation. Treatment of coexisting anxiety or depressive disorder may be effective in alleviating symptoms of dhat (Bhatia 1991). However it is important to advice that introducing psychological language as a way of understanding a problem is also introducing a culture-specific concept of the person,

which may be in conflict with the values and views of the patients' culture of origin: this may create new dilemmas for them. Psychiatric diagnosis and treatment— even the prescription of medication—must then be understood not simply as technical interventions, but as interpretive actions aimed to improve the psychological and social status of individuals and families that also, inevitably, contribute to wider social and cultural change.

Professional psychiatric practice assumes implicitly, according to Western concept of the person and with the values of "expressive individualism" (Bellah 1985, Kirmayer 1989), that people will be healthier if they talk openly about their emotions and relationships, and that when there is an internal or interpersonal conflict, it should be resolved in favour of the autonomy of the individual. But emotions are also social constructions (Markus and Kitayama 1991, Ortony et al. 1988, Harré 1986, Russell 1991, Fivush 1994). Nilchaikovit (1993) notices that in many cultures, in particular some Asiatic ones, to talk about personal experiences is something discreet as to appear naked in public. A similar parallelism may be used for problems inside the family, the causes of death of relatives or issues regarding sexual relationships (Hsu 1983, Tseng 2001). Psychological talk about emotions tends to situate problems entirely within the individual and may distract the patient, his or her family, and the clinician from the social and situational problems and inequities that are signalled by the emotion.

2.4 Migrant studies and psychosis

Different rates of diagnosis of psychosis

The first cases of higher rate of psychosis in migrants go back to 1932 with Odegaard study, which observed an incidence of schizophrenia among Norwegian migrants in the USA which was 2 times higher than the one reported for the local population and than the one of Norwegians living in Norway (Odegaard 1932). Similar findings were replicated in USA and UK in the following years, involving migrants from many different origins (Malzberg 1955, 1964; Kiev 1965; Hemsi 1967; Dean et al. 1981; McGovern et al. 1987; Harrison 1988, 1990, 1997). DSM-IV-TR acknowledge that in Western countries the relative risk of being diagnosed as psychotic is higher for migrants with Afro Caribbean, Sub-Saharan and Asiatic origins, than for the local white population.

A meta-analysis and review established that the relative risk of being diagnosed as psychotic for migrants is 2.7 for first generation migrants and 4.5 for the second generation migrants. Moreover, the risk seems higher for black migrants, with a relative risk of 4,8 respect the risk of other migrant groups, which is as whole of 2,9. Other risk factors seem to be linked to the distance between the mother country and the host country and if the person comes from developing countries (Cantor-Graae and Selten 2003, 2005). It seems that bigger the distance, higher will be the interpersonal stress and the cultural shock. Moreover, migrants coming from developing regions, in the majority of cases, see in migration the possibility of changing a situation of great poverty and difficulty, but when high sources of stress emerge even in the host country this can lead to an emotional and existential instability ((Maharajh 2005).

Different symptoms and environmental factors

It is still not clear which are the origins of this phenomenon in the contemporary migratory context. As a result of numerous international researches some hypotheses have been refuted: a greater migration of individuals predisposed to the development of schizophrenia (McKenzie et al. 1995, 2002; Cantor-Graae et al. 2003, 2005; Bogers et al. 2000) together with the hypothesis of a greater ethnic genetic vulnerability, since, there are lower rates of diagnosis of psychosis in the Countries of origin of the migrants (Mahy et al. 1999, Hanoeman et al. 2002, Selten 2005, Hickling et al. 2001, Bhugra et al. 1996).

There are other hypotheses that have been confirmed and are waiting to be further investigated. The main ones regard:

1) a different presentation of symptoms in Afro Caribbean and Sub-Saharan patients, that leads to misdiagnosis of psychosis in case of bipolar disorder. Many researches show that black patients in USA and UK experience more positive symptoms and more single hallucinatory experiences than the majority of the population (Strakowski et al. 1996, 1997; Arnold et al. 2004; Sharpley et al. 1999, 2001; Johns et al. 1998, 2002). In a study Johns et al. (2002) show that just 25% of them meet the criteria for diagnosis of schizophrenia. Culture can give different values and meaning to hallucinatory experiences. In some non-Western countries these kind of phenomenon are more common, since they aren't considered as symptom of a mental health disease, but as part of the education and ritual part of the life of a person in the community. Therefore in a Western context it may be difficult to distinguish pathological hallucination from cultural related experiences (Neighbors et al. 2003, Zolkowska et al. 2001 Hutchinson et al. 2001, Kirov et al. 1999). Encouraging individuals to fantasise in non-Western societies tends to facilitate social control by reinforcing commonly shared hallucinations and extinguishing the idiosyncratic ones (al-Issa 1995). This may also be useful to become more familiar with fantasy, imagination and people's inner world, in a quite similar way of the use of self monitoring in behavioural treatment (Bentall 1990).

2) a higher compulsory admission rate and police involvement that could bring to a negative attitude towards the western health care system, to a delay in the search for help and to an aggravation of the symptomatology (Bhui et al. 2003, Morgan et al. 2005, Arnold et al. 2004, Neighbors et al. 2003);

3) the difficulty in conciliating two different cultural identities and the acculturation stress (Sharpley et al. 2001, Harrison et al. 1988);

4) a possible encounter with pathogenic factors that is rarer in the context of origin of the migrants, like the Toxoplasma gondii (Yolken et al. 2001).

More research is still needed, to gain a clearer understanding of these results, also because these

studies carried out on migrant populations could play an important role in helping to better understand the aetiology of psychosis, with reference to a bio-psycho-social model.

Among migrants three widely recognized ways in which people explain the aetiology of illness and distress that are widely used across cultures are a) "stress,"

b) " pollution," and c) "traumatic memories." These terms may often be used to clarify some differences in the respondents' state of health before and after immigration. For example the idea of pollution often focuses on foods that are not available in Western countries. These accounts are "environmental" in the broadest sense of the word, because they allow respondents to articulate a constellation of social, medical, and personal meanings in a narrative context. Whereas the notions of "stress" and "pollution" are probably instances of "organizing metaphors" (Kirmayer 1992). The traumatic event corresponds to a "chain complex" in which a sequence of experiences or events provides the logical structure of the narrative.

3) Pathways to care

The international literature shows that in Western nations, ethnic minority groups experience difficulties accessing mental health care. Members of ethnic minority groups are underrepresented among patients receiving mental health services (Snowden and Cheung 1990, Vega et al. 2001), with relative over-use of the ER (Leduc e Proulx 2004). Fitzpatrick and Freed (2000) study shows that many migrants tend to use the ER many times for the same problem, using in an inadequate way the services. Research on the use of outpatient mental health services has shown lower rates of utilization by minorities. Promoting the use of outpatient mental health services by minorities can have a positive effect on the overall cost of health and mental health care, as well as increasing access to care and quality of care for minority populations (Wallen 1992, Hu et al. 1991) reported that Asians and Hispanics poorly used the emergency room and inpatient care but they had more outpatient care than did Whites, whereas Blacks used more the emergency room and less outpatient care. Regarding emergency and inpatient care, Asian and Hispanic patterns of use appear relatively favorable, whereas the patterns of Blacks continue to be problematic. Obviously in this case it's not possible to plan for them effective prevention and treatments. This may be due to a lack of information or access to health care services, but also to some cultural expectation related to treatment. Infact in some non-Western countries is less important the concept of continuity of a therapeutic relationship (Tseng 2003) and the expectation is that once you have no more symptoms you are no longer ill , so you don't need to continue a follow up. Obviously this is in contrast with the western concept of therapy, especially in a psychiatric context.

In the UK and US this pattern related to Blacks goes together with other differences in pathways to care (compared with other ethnic groups) found over the past 20 years (Fernando 2005). They are more often:

- compulsorily detained in hospital (Bhui et al. 2003, Morgan et al. 2005, Arnold et al. 2004, Neighbors et al. 2003, Commander 2003)
- admitted as 'offender patients' (McGovern & Cope 1987);
- held by the police for observation for mental illness (Dunn & Fahy 1990, Pipe et al. 1991, Rogers & Faulkner 1987);
- transferred to locked words from open wards when they are patients in hospital (Bolton 1984);
- given high doses of medication when they are patients in hospital (Chen et al. 1991, Littlewood & Cross 1980, Lloyd & Moodley 1992);
- not referred for psychotherapy when suffering from mental health problems (Campling 1989).

4) Models of services

Kirmayer et al. (2003) clearly demonstrated the impact of cultural misunderstandings in a clinical setting: incomplete assessments, incorrect diagnoses, inappropriate treatment and failed treatment alliances. To address these issue, cross-national comparative perspective can shed light on alternative models or services (Kirmayer & Minas 2000). These services range from increased training of the general staff in cultural competence to utilization of specially trained mental health translators and cultural brokers to ethno-specific mental health services. Matching clients with providers who speak the same language and have the same ethnic background, has been found to improve mental health outcomes (Ziguras et al. 2003, Bhui et al. 2007). Here are some examples:

USA

In the USA there is an important literature on the effectiveness in the services of ethnically match of users and professionals. (e.g. Rosenheck et al. 1995). One example is the Ethnic/Minority Psychiatric Inpatient Programs at San Francisco General Hospital (SFGH) that, since 1980, has provided culturally competent services to underserved populations (Zatzick and Lu 1991). This service is defined by Francis Lu, Director of the Cultural Competence and Diversity Program, as "striving to provide the highest quality of care to individuals with severe mental illnesses who largely depend on the public sector". The inpatient facility consists of 5 acute diagnostic and treatment units with a total of 97 beds. Each unit has developed a focus reflecting the cultural diversity of both San Francisco and the patients served by the hospital. These are the current Focus Programs: Asian, Latino, Women, Black people, Lesbian/Gay/Bisexual/Transgender, HIV/AIDS, Forensic. The focus concept brings together multidisciplinary staff, faculty and trainees to work with patients who could benefit from their cultural and linguistic expertise related to diagnosis, assessment and treatment. Physicians, nursing staff, social workers, occupational therapists, and psychologists comprise the staff. Trainees include PGY-1 psychiatric residents;

medical students; psychologists; and social work nursing and occupational therapy students. The focus concept is not a form of segregation since there is staff and patients of many ethnicities in all units.

UCSF utilize Asian Focus Unit as a transcultural training experience for residency students' education. They rotates for a 6 months period, directly caring for ethnic minorities patients and working with ethnic staff as part of a multidisciplinary team (Zatzick and Lu 1991).

Disparities in access to services in the US are largely related to lack of insurance. In 2004, 45.8 million people were without health insurance coverage, up to 45 million people in 2003, with no change in the percentage of people without health insurance coverage (15.7 percent) between 2003 and 2004. This lack of insurance affected especially Latino and Asian-American communities. Forty percent of Latinos have no health insurance, and for Latinos who have been in the United States less than five years—and for that reason are eligible for Medicaid—the rate is 58.6 percent (Moran 2006).

UK

According with what are now called the NHS Plan and the National Service framework objectives, a variety of projects have been tried within the statutory sector (NHS), with the aim of meeting the needs of black and ethnic minorities communities (BME). Often, these projects have been dependent on the commitment and enthusiasm of one or two people; when they leave, the 'special service' has come up against difficulties and usually disappeared. The main approaches that have informed projects in the statutory sector are as follows:

- training professional staff in 'cultural sensitivity and 'anti-racist practice';
- cultural consultancy based on a multicultural multidisciplinary team;
- transcultural unit within a mental health service that promoted professional expertise in helping people from a variety of cultural backgrounds;
- service led by professionals from similar ethnic backgrounds to those of clients;
- anti-oppressive practice in dealing with people from BME communities;
- linking psychological support to housing;
- using 'black therapy' and emphasis on spirituality by linking up with black churches.

No clear-cut single 'good practice model' for multicultural services has emerged in the UK. Likewise, in studying mental health and social care for refugees and asylum-seekers in European countries Watters and Ingleby (2004) have noted, that there are a variety of good practices but no overall consensus on a single good practice model (Fernando 2005). The statutory sector has mainly catered only for those groups with severe mental disorders, but not addressing the needs of the majority who have less severe mental disorders.

Bhui (Bhui and Sashidharan 2003) rightly points out that the majority of ethnic minority services, mostly for black and Asian communities, are run by the voluntary sector and are outside the National Health Service (NHS). The following approaches have been applied to the projects:

- adapting traditional counselling by learning from clients;
- using skills of therapists derived from their own cultural backgrounds and community links;
- using alternative therapies derived from Asian cultural traditions;
- supportive therapies linked to housing and social integration;
- advocacy to help clients to deal with statutory services;
- therapies aimed at community integration;
- guidance to clients on strategies to deal with racism.

Fernando (Fernando 2005). Reported that, from a discussion with both therapists and clients at several black voluntary sector projects, the counselling practised at the centres is generally appropriate and helpful – something that is often not the case at statutory services. Many of the projects cater to a particular ethnic group or subgroup (Black, Asian or, sometimes more precisely, Chinese, Somali etc.) The staff in each project would mainly or exclusively belong to the designated ethnic group or one culturally very similar, or else have had close connections with people from the designated background. Therefore, many of the approaches in the projects resemble those advocated by Waldegrave (2003) in working with three communities in New Zealand. Many of the services operate on a much less formal setting than do traditional counselling services. Practical arrangements are flexible both in relation to time keeping and venue at which clients and staff meet. Their limitations include:

- limited involvement of NHS psychiatrists;
- targeting of only certain ethnic groups;
- restriction to small geographical areas; and short-term funding (Bhui/Sashidharan (2003) raise important questions in the debate on whether there should be separate psychiatric services for ethnic minorities in the UK (ismail 2004). In planning culturally competent services, the notion of a specific service for each cultural group seems unrealistic. Infact in areas where 25% of the population are ethnic minority groups speaking up to a hundred languages, creating services for individual ethnic groups seems unattainable (Yang et al. 2005). There is another problem in that specific services for ethnic minority groups raise fears of 'ghettoisation' and further marginalisation of those already marginalised. They believe that the solution for the current problems must involve the mainstream of psychiatric practice, to avoid turning a blind eye to the needs of our multicultural society .

Canada

Montreal

The cultural consultation model developed in Canada attempts to take into account culture specific factors to improve diagnostic assessment, treatment planning and case management. The enormous diversity of Canadian society is not captured by the broad ethno-racial categories commonly used in the UK and USA; thus, specialised clinics for each minority group are not feasible. The consultation model draws on a bank

of translators, culture-brokers, anthropologists, religious informants, traditional healers and mental health professionals who can be appropriately assembled to help referring clinicians with assessment and treatment. The aim is to improve the quality of care at all levels of the health care system rather than segregate ethnic-groups. Every consultation is an opportunity for in-service training of referring clinicians, with an emphasis on transfer of knowledge. This increases their cultural competence and facilitates collaborative work with culture specific resources in both the health care system and the community (Waheed et al. 2003). After an evaluation of this service clinician referring patients to the service reported higher rates of satisfaction with the consultations (Kirmayer et al. 2003).

Cultural consultation may take 1 of these 3 forms:

1) a consultant with relevant cultural expertise assesses the patient. It's better if a referring person is present. Usually a complete assessment will take 1-3 meetings. After this, a detailed consultation report and a brief written report or case conference will follow for the immediate recommendations.

2) The cultural consultant discusses the case with the referring clinician, without assessing directly the patients. Clinicians may also present the case during clinical conferences, where CCS team members and invited consultants discuss the case and make recommendations.

3) CCS consultants meet with a referring community organization, that present recurring problems and concerns they meet serving a specific cultural community, without the presence of community members. CCS team members and invited consultants discuss the issues and make recommendations.

This model proposes the operation of a specialised multi-disciplinary team that brings together clinical experience with cultural knowledge and linguistic skills essential to working with patients from diverse cultural backgrounds. A team built on the cultural consultation model aims to give advice to other clinicians rather than take on patients for continuing care. The latter will be reserved for cases where there are difficulties in understanding, diagnosing and treating patients where cultural factors may be important. The assessment will usually involve two or three interviews with the patient and his or her family, which should result in a clear cultural formulation, diagnosis and treatment plan. The members of this team will be a resource for clinicians in primary care, social services, mental health and other related disciplines. They will also be involved in the training of interpreters, culture link workers and members of the mainstream and existing community services.

Toronto

Another interesting experience is the assertive community treatment team for ethnic minority persons of the department of psychiatry at Mount Sinai Hospital in Toronto directed by Dr. Law. A review of the team generated a score of 13 out of 14 points on the Index of Fidelity of Assertive Community Treatment (McGrew 1994). The team consists of ten full-time equivalent staff; the clinician-client ratio ranges from 1:6 to 1:10. The services focused in this area on East and Southeast Asians, African, Caribbean, and aboriginal populations, following the indications from local surveys on the primary need for ethno culturally groups. The design of the supportive programming, community agency partnership, and staff composition reflected this focus. All staff is bilingual and shares the cultural backgrounds of one of the key ethnominority groups identified in the surveys. In all the team's clinical assessments, encounters and clinical supervision, the Illness Narrative model from Kleinman has been incorporated (Yang et al. 2005). Expertise has been developed in assisting patients to deal with immigration issues, refugee claims, and social assistance matters, as well to highlight specific cultural issues, such as culturally influenced stigma, a lack of trust of authority, compliance with medication, or use of alternative health practices. To engage patients, culturally sensitive, meaningful group activities are strongly incorporated into regular programming (Chinese noodle, yoga group). Different seasonal and festival celebrations from diverse cultures are incorporated into the timetable to enhance cultural understanding and promote mutual respect.

An acculturation assessment was used as part the psychosocial evaluation for all patients and an individual treatment plans was developed accordingly. The patients treated until now has been found to have low levels of acculturation, difficulty understanding and speaking the languages of the mainstream culture and lack of family support. To support and promote family involvement in the patients' care, they provide family members with psycho-education in the patients' native tongue.

From a 1 year survey a significant reductions in hospitalization rates were noted, by 5,874 days, from 7,095 days to 1,221 days—an 83 percent reduction. This seems a fairly good result, because it exceeds the expectation reported in the literature. Tibbo et al. (1999) in Canada reported an average reduction of 56%, while the meta-analysis in the United States by Bond et al. reported about 50% (Bond et al 1995, Yang et al. 2005). This goal is central to the mission of assertive community treatment programs and is one of the essential determinants in the reduction of overall cost. The consumers answered evaluating positively the experience, as from the result of a survey.

5) Conclusions

As clinician of a multiethnic world, it is increasingly important to develop a cultural competence, in a way to better understand others as well as our own culture. Training in medical school and residencies is now expected to cover health disparities. It seems urgent that medical schools and residency programs integrate health care for individuals from minority groups throughout the entire curriculum and it is important both to train more minority psychiatrists and to expand the skills and knowledge of all psychiatrists in the area of minority mental health (Rosenheck et al. 1995, Atdjian and Vega 2005)

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