Cross Cultural Newsletter

10 December 2012

Dear Members

This is the last newsletter of the year, our 10th one. I wish to report that we had a very successful year. Last night's meeting is but an example of this. Around 60 of our members attended. They were most enthusiastic in the discussions.

The topic was on "**PRACTICAL ISSUES IN CROSS-CULTURAL MENTAL HEALTH PRACTICE: A WORKSHOP AND PANEL DISCUSSIONS".** Panel members were: Patrick Au, Dr Ashok Malur, Ms Renuka Wali and yours truly.

Tribute was also paid to Corinne Friebel, psychotherapist who would be serving us in the Audience by making suggestions from the Audience's perspective. I also thanked Ms Sue Lim, manager of the Asian Support Services of Waitemata DHB, who has, in the past decade, unflinchingly and relentlessly supported our programme. For all intense and purpose, the Cross Cultural Interest group is a joint project between ADHB, WDHB and our small trust called Chinese Mental Health Consultation Services Trust. The above is but to clarify to our members the agencies behind our group.

Having dwelled too much on administration issues, let me provide you with a summary of last night's proceedings. Although every attempt has been made to provide the privacy for the real owners of these vignettes, members should still keep confidentiality about the contents as much as they could because the facts of the stories are true. This would also apply to members who request for future DVDs. They should refrain from spreading them or copying without our consent. Apart from confidentiality, the two pillars upholding clinical practices are:- evidence-based and consensus practice. The evening's meeting aims at seeking consensus and sharing experiences. As such there is no single solution to the problems that is correct .There still remains many other ways to "kill the proverbial cat".

Major practical issues in cross cultural practice often involve diagnosis, management and more importantly ethics. Vignettes were presented to highlight each of these areas and pertinent comments made by the panel and discussed at length with the audience.

In terms of diagnosis, the difficulties are often related to where culture ends and major universal conditions begin, the so-called "Act of Culture" and "Act of God". I showed a video-clipping as a starter to introduce a continuum model to explain how a normal cultural reaction and coping could be high jacked by individual vulnerabilities (including psychological suggestibility and biological vulnerabilities) to progress along the continuum from normal reaction, through discrete culture bound syndromes, to the more serious pervasive universal disorders - what is known as a "bottoms up progression". This model also has another component -a "top down progression" in which an originally biological/ universal disorder could take on a cultural flavor because the patient has been utilising cultural explanations to attribute the cause of symptoms in order to make sense out of them (i.e. de-mystification). (This is known as patho-plastic effects of culture). In deciding the contribution of culture, the pitfall is often that the clinician could become polarized (i.e. either cultural or biological biased) and overlook the interaction between culture and vulnerability, thus leading to missing some of the important issues, e.g. having missed the psychotic symptoms, or vice versa. It is hoped that the model presented would allow a clinician to adopt a holistic and flexible approach, and more importantly, cognizant of the fact that the nature of the presentation can change over time according to vulnerabilities. Two vignettes were used to illustrate the point.

The next issue to address was management: what is insight and who determines this. Insight is both of diagnostic and management importance. The lack of insight would often be seen as the hallmarks of psychosis and a basis for committal. Lack of insight also affects the patient's acceptance of treatment. The panel asked who should be making decisions about the reality of a patient's insight, the clinician or the patient's own culture. This is especially pertinent across cultures where attribution of problems vary. If a patient's insight is culturally real or relevant, but not what the main stream clinician

would expect, should the patient be deemed to have no insight? Further difficulties arises when, basing on the cultural relevant insight, the patient refuses treatment derived from foreign concepts (i.e Occidental treatment) but accepts traditional treatment the effectiveness is not proven. The worse scenario is when a risk is present, posing further challenges to the treating clinician. Under these circumstances, what is the best practice? The consensus is that the best practice would be to try to compromise. An attempt should be made to reframe occidental treatment to put this in line with patient's culture relevant insight. This process, called bridging, would often facilitate the acceptance of Western treatment. A case was used to illustrate the point.

In the realm of ethical dilemmas, three vignettes were used to illustrate the 3 issues often encountered. The first scenario is when a clinician rigidly adheres to western ethical principles such as confidentiality and informed consent, but overlooks the clinical requirements of the patients and their families. Rigidity of observing privacy is illustrated by a case in which the clinician requires informed consent for all meetings about the patient to be obtained including intra-service management meetings, thus delaying the process of treatment planning. Another case illustrates the dilemma between committing the patient and forcing the latter to receive treatment thus humiliating the patient in the process on the one hand, and on the other, to regard the cultural shame, the fear the patient has about legal involvements, and the age-honoured compliance to authorities in receiving treatment (often without need for a signed consent) but to ignore or relax on the legal requirements for a formal and informed one. In this scenario, it was the latter fear of being involved legally like a criminal that resulted in a patient killing herself. In this case, the issue of implied consent was brought up and discussed. In some countries, no mental health act is necessary to enforce treatment. Ethical issues vary across cultures. But, it is always a balancing between which set of values one prioritises: whether it is for short term protection of rights and freedom, or for long term freedom from the bonds of sickness. Loss in interpretation is our third vignette in which crucial information required for treatment consent has been omitted during interpretation. What are the clinician's ethical and legal responsibilities? It was felt that where such are deemed important, having the important issues written down as a basis for the interpreter to translate from would provide formal documentation. Interpreter training to render reliable interpretation is of course a given.

Finally, the vignette: "a bunch of arrows are harder to break" illustrates the difficulties in which multiple treatment modalities, including use of herbs, are utilized concurrently in the patient's management. Unfortunately, there was insufficient time to discuss this. Instead, a handout on guidelines to advise patients on concurrent herbal medication use was given out to the audience.

The panel discussion did not finish until well after 8pm, followed by a lot of further discussions among members themselves after the workshop ended.

A DVD would become available soon. However, as always, please keep the strictest confidence. The DVD is intended for members only. **Please do not circulate.**

Preview of 2013

PREVIEW OF ACTIVITIES FOR NEXT YEAR.

It is our intention to have similar workshop/panel discussions in the future. One topic will be on "Family therapy—the practical difficulties and dilemmas involved."

We have now come to the end of 2012. The next session would likely start again on the fourth Tuesday of February 2013.

Lastly, on behalf of the Cross Cultural Group, let me take this opportunity to wish you a Merry Christmas and a fruitful New Year. Thank you again for your support without which we would never have endured a full decade.

I look forward to seeing you all in our next meeting, 2013.

Yours sincerely,

S Wong

On behalf of the Cross Cultural Group