



A culturally sensitive consultation model*

Jill Benson

*Health in Human Diversity Unit, Discipline of General Practice, University of Adelaide, South Australia
Migrant Health Service, Nunkuwarrin Yunti, and Parklands Medical Practice, Adelaide, South Australia*

*Reproduced with permission of The Editor, *Medicine Today*: Benson, J. (2005). A culturally sensitive consultation model, *Medicine Today*, 3(2), 84-89.

Abstract

Cultural sensitivity is not only about those patients who come from a different country to that of the practitioner, but also includes those with other differences such as family background, education, religion, belief system or socio-political outlook. If the patient feels their beliefs, values and practices are understood and respected by the practitioner, there is an increased likelihood a good relationship will be established and the patient will trust the doctor and the clinical procedures. To be more culturally sensitive in consultations, three additional variables – ethnocentrism, health literacy and transcultural perceptions of illness – need to be taken into account. It is near impossible for doctors to undertake education for themselves on the ever-growing variety of cultural factors that can influence the interaction with patients. Some practical ways of communicating are outlined in the use of the *Cultural Awareness Tool* and Narrative Therapy.

Keywords

cultural sensitivity, ethnocentrism, health literacy, narrative therapy, Aboriginal health, refugee health, multicultural mental health

Introduction

Cultural sensitivity is not only about those patients who come from a different country to that of the practitioner, but also includes those with other differences such as family background, education, religion, belief system or socio-political outlook. Essentially, culture is about the individual ‘self’ and how that self is influenced by the surroundings in which it has developed. Culture provides people with a framework within which they can relate to one another and co-exist. It is a means for the transmission, over time, of ideas, values and customs, and, more generally, ways of living. It

is a ‘system of meanings that is learned, that provides people with a distinctive sense of reality and which helps shape behavior and affective responses’ (Thakker & Ward, 1998).

When thinking about how to be more culturally sensitive in consultations, doctors need to take into account three additional variables - ethnocentrism, health literacy and transcultural perceptions of illness.

Ethnocentrism

Ethnocentrism is the normal tendency of each individual to see the world from the viewpoint of their own ‘tribe’, the sub-culture that is the most

Contact: Dr. Jill Benson, Director, Cultural Diversity Programme, Health in Human Diversity Unit, Discipline of General Practice, University of Adelaide, South Australia, 5005 jillb@bigpond.net.au
Citation: Benson, J. (2006). A culturally sensitive consultation model. *Australian e-Journal for the Advancement of Mental Health* 5(2) www.auseinet.com/journal/vol5iss2/benson.pdf
Published by: *Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)* – www.auseinet.com/journal

dominant in their life. It is 'the price to be paid so that the systems of values of each spiritual family or each community are preserved and find within themselves the resources necessary to their renewal' (Geertz, 1985).

Such ethnocentrism is difficult to quantify however, because it frequently exists at an unconscious level, or at least tends to be so pervasive that it escapes everyday thought (Columbia Encyclopedia, 2001).

Practitioners have their own socialised and cultural view of what constitutes 'normal', and it is from this position that they assess their patients. Professor Issy Pilowsky, who was Professor of Psychiatry in Adelaide, South Australia, from 1971-1997, taught that doctors assess a person's mood within a half a second of their meeting. Such an opinion will often be culturally based, and hence it is important to consciously challenge this automatic initial assessment. It is imperative for doctors to suspend their own belief system and to find out what is truly happening in the patient's life, from the patient's different cultural viewpoint. The doctor needs to have a conscious awareness that the patient's culturally based subjective experience and idioms of distress, diagnoses, expectations and outcomes will probably be different.

Even the conservative DSM-IV says 'diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group ... a clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, belief, or experience that are particular to the individual's culture' (American Psychiatric Association, 1994).

For as long as psychiatry has existed, it has sometimes been inappropriately used as a socio-political tool to 'explain' behaviours that are disapproved of by the dominant culture. As practitioners using a Western model, it is important not to unconsciously fall into the trap of doing the same, when psychiatric diagnoses such as somatisation, abnormal grief reactions and factitious disorder are discussed.

'It is not sufficient that society expresses disapproval of a particular behavior through the application of a diagnostic label. Rather, there must be a problem within the individual which interferes with his or her ability to function... A disorder exists when the failure of a person's internal mechanisms to perform their functions as designed by nature impinges harmfully on the person's well-being as defined by social values and meaning' (Wakefield, 1992).

Health literacy

Improving the patient's health literacy will decrease their fear of illness, investigation and treatment and give them more control over their own health and lives. The *Ottawa Charter for Health Promotion* (World Health Organization, 1986) states 'Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health'.

Health literacy in itself seems like an ethnocentric concept as it implies that the Western view of health is the 'literate' one. It also takes into account however the fact that Western medicine has a body of research and evidence that can be shared with patients. One of the main roles of practitioners is education, whether it is anatomy, physiology, investigation, treatment, consequences, side effects or allaying of fears. A common complaint about doctors is that they speak their own jargon which is unintelligible to patients. Both parties need to be 'speaking the same language' about the condition that is being discussed, even if they are not speaking the same cultural language. When treating and communicating with patients from some cultures, it is important to acknowledge that a hierarchy based on gender, age, religion and relationships can influence whether or not the patient will accept advice or information.

On occasions, patients may present with an illness which can't be defined from a biological viewpoint or where there is an established cultural treatment that is not based on evidence. Education about allopathic medicine should be additive to their beliefs unless they are seen to be harmful or abusive. A combination of the two

forms of therapy may increase patient compliance and improve the relationship between patient and doctor (American Medical Student Association, 2004). Many patients will not have a level of health literacy that gives them an ability to sort through symptoms, signs, consequences of illness, side effects and so on, such that these issues can be appropriately prioritised. This means that patients will sometimes present with a complex and seemingly random array of problems.

For a diagnosis of mental illness in particular, the distress and disability must be a response that is considered 'abnormal' within the person's own culture and be able to be viewed as a dysfunction in the individual. However, there seems to be a universality about mental illness and its treatment that needs to be communicated to patients in words and concepts consistent with the patients' own understanding and expressions of that illness.

Work with PET (positron emission tomography) and MRI (magnetic resonance imaging) has shown what happens in the brain with mental illnesses such as depression, anxiety and post-traumatic stress disorder. Changes which occur with the use of both medication and psychotherapy can be mapped using these modalities. 'What we did there is compare responders to treatment to nonresponders, and what we found is that responders to treatment had decreases in activity in the ventrolateral prefrontal cortex and the orbital frontal cortex... Nonresponders did not have these decreases in activity' (Knowlton, 2001). Biology thus reflects and reveals mental functioning.

Perception of illness

Anthropologists distinguish between two cultural concepts that influence how people think about themselves in relation to their communities. The 'ego-centric' concept is of a 'person who was individualistic, with an identity that emphasised uniqueness, derived from his or her distinct biography'. This concept is usually a Western way of thinking. The 'socio-centric' person is embedded in the context of 'membership of the social group to which he or she belonged' (Shweder & Bourne, 1984). Indigenous cultures tend to be examples of this. 'When treating a patient from a culture in which there is a strongly

socio-centric concept of what a person should be, it would be all too easy to think that the patient was being passive and dependent, with an external locus of control, when in fact all he or she was being was a normal person in that society' (Barrett, 2001).

Culture and language give humans the basis with which to grapple with deeper concepts and choices, the foundation of which begins in childhood. From birth to adolescence, the brain is learning about its environment. 'It was long believed that a spurt of overproduction of gray matter during the first 18 months of life was followed by a steady decline as unused circuitry is discarded. Then, in the late 1990s...discovered a second wave of overproduction of gray matter just prior to puberty, followed by a second bout of "use-it-or-lose-it" pruning during the teen years' (National Institute of Mental Health, 2004).

Hence when looking at the expression of depression as, for instance, somatisation in some cultures, it is not helpful to try to challenge the resistance to viewing the illness as a psychiatric rather than a physical condition. This is not about 'locus of control' or 'psychological-mindedness' but about a different cultural expression of a neurophysiological phenomenon that is 'hard-wired' in the brain.

Consider an age-dominated 'sub-culture' such as students at Adelaide University, tending to present with anxiety, fatigue and difficulty with their studies. Their main concerns are usually relationship problems or the consequences of failing their exams. Many of them are very young and come to the doctor with minor illnesses that are often the result of anxiety and insecurity. Others may blame their studies for their problems and can become even more upset if depression is cited as the cause. For some this situational crisis can lead to 'sub-cultural' ways of dealing with the issues with drugs, alcohol or even suicidal ideation. The doctors at the University practice like to focus on such concepts as 'reaching their coping limits' as a means of approaching diagnosis and treatment of the problems.

In contrast, Australian Aboriginal people, like most other indigenous populations throughout the world, are often steeped in illness, grief and

loss as their primary presentation of depression. Alcoholism, domestic violence, lack of self-care, withdrawal and unemployment, as consequences of depression, add to the overwhelming social problems faced by many of these people. Three of the biggest issues in Aboriginal communities are the high incidence of suicide in young men (up to 3 times higher than the rest of the population), the increased incidence of violence, especially against women (19 times greater than for non-Aboriginal women) and the rate of imprisonment (12 times higher both for men and women). The life expectancy for the Australian Aboriginal population is 20 years less than for the non-Aboriginal people (Australian Bureau of Statistics, 2003). When treating illnesses such as chronic obstructive airways disease (COAD), diabetes, alcohol-related illness, injury, dental problems and so on, doctors need to be aware that depression, social issues and self-neglect may be complicating factors that need to be treated alongside the physical conditions.

Watters (1999) discusses his experience of mental illness in refugees in the United Kingdom. 'It may not always be helpful to refugees to have their distress articulated through conventional Western definitions of psychological ill-health. Refugees suffer language and communication difficulties and a lack of understanding of the culture, religious beliefs and attitudes of the host country, and resultant misunderstandings can lead to a misdiagnosis of mental illness.' He continues, 'central to establishing appropriate services is a willingness to integrate mental health and social care into a holistic approach. Refugees rarely view their problems as about mental health. When questioned most talk in terms of basic needs such as housing, employment, education and being able to re-establish links with family members' (Watters, 1999).

However, it is important that practitioners who are interested in the cultural and religious aspects of their patients do not 'resort to national or racial stereotypes that serve, ironically, to obstruct empathic understanding rather than enhance it (Barrett, 2001). Cultural sensitivity is also about being aware of the core personal differences such as family, politics, education, finances, religion, sexuality, ethics or local

community, that are integral to everyone. Whenever a practitioner and a patient are communicating, there will be cultural differences that are fundamental to both parties that will be mediating the interaction.

Cultural Awareness Tool

It is near impossible for doctors to undertake education for themselves on the ever-growing variety of cultural factors that can influence the interaction with patients. One useful way of communicating in a consultation is outlined in the *Cultural Awareness Tool* (Seah, Tilbury, Wright et al., 2002) and is based on a series of questions developed by Arthur Kleinman in 1978 (cited in Kleinman & Good, 1985). It involves a change in the way of relating whereby the 'patient and family members take on the role of experts while you break out of your doctorly role for a moment to become a student intrigued by their culture' (Barrett, 2001). This is in contrast to the blunt line of questioning sometimes used and emphasises a respect and curiosity for the patient's different way of viewing their illness. The questions are not prescriptive but reflect the usual movement of a consultation through symptoms, past history, assessment of severity, safety issues, treatment, safety net and so on. With experience in different cultural settings, the style of questioning can be refined and rendered more specific for that culture. They can also become more 'embedded' as part of a generalised conversational flow. The following is an adaptation of the questions from the *Cultural Awareness Tool*, refined to suit the experience and practice of this writer.

1. What is the main problem you would like me to help you with today?

This initial question may or may not reveal the main problem that needs to be addressed but will give insight into what is going on in the person's life. If they come from a background where mental health problems are taboo or not part of the culture, they may discuss physical complaints such as backache, headache, diarrhoea or abdominal pain. Sometimes they will talk about social problems such as family difficulties, housing, employment, finances or grieving issues. However, often they will complain of more recognisable symptoms such as insomnia, fatigue, anxiety, depressed mood,

inability to work, withdrawal, anger or irritability. Whatever the presenting symptoms, the rest of the questioning must primarily focus on that issue as an entrance into the patient's inner world.

2. How is this problem affecting you?

This enquiry will usually provide a broader set of complaints, and if the patient is depressed may lead to the diagnosis. Some see their 'worrying' as perfectly normal and even respectful and will discuss physical symptoms and social factors as the cause of their psychological problems. The patient will see the initial problem as the cause of the symptoms, not something called depression, and this must be respected as the consultation continues. It is important to remember that stigma and taboo can be associated with depression in most cultures and that for many, somatisation is the only way of expressing their illness.

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

Often a question such as this will help both the patient and the doctor to gain insight into what the precipitating factor is and hence make the diagnosis clearer. This may also bring to light religious beliefs associated with the illness. There is a wide range of beliefs about what causes mental illness. Some believe that it is because the person has done something wrong or bad, that it is caused by evil spirits or bad deeds in an ancestor, that it is a weakness, that it is contagious, that the medication makes it become entrenched and the patient can never get off it, or that it is the responsibility of the family to deal with it without medication.

4. What do you most fear about this problem?

As well as being an opening to allay the unrealistic fears that many people have about their illnesses, this may give the doctor an idea of what are the priorities in the person's life, for example job, family commitments or dying at an early age. If the patient comes from a culture with little knowledge of anatomy and physiology this might be an opportunity for education that will help them gain a deeper understanding of how psychological issues such as stress, anxiety, depression, post traumatic stress disorder and grief can affect their physical health.

5. What solutions have you tried or have you thought of?

This can be a way of both assessing the severity of illnesses such as depression and suicidality, and also seeing if there is a cultural treatment for the problem. Often people will discuss what their own culture would do in this situation and it is important to attend to this in order to gain more insight into these cultural beliefs. Respecting the patient's own ability to deal with their problems, and listening to what happens on those occasions when they have found an answer, can also build up a different therapeutic relationship. The doctor can stand then, with the patient, the health worker, the other health professionals or family, and look together at the problem. This approach where the problem is 'externalised' and the 'community' is involved in finding the solution is often much more familiar and acceptable to the patient than the usual Western allopathic, biological, secular approach to mental illness. Standing together with the patient and developing a knowledge and management plan that is mutually acceptable may help to decrease the non-compliance rate from its current level of about fifty percent.

6. What were you hoping that I would do for you today?

This is an extremely important question that doctors don't tend to ask of their own cultures. The expectations can range from a housing letter to a script for a medication to massage. If the patient's expectations can be met (form filled in, masseur found), a trusting therapeutic alliance has been formed that may then allow other suggestions for treatment to be made, either at this consultation, or in the future.

7. How can your family and community help you with your problem?

Central to establishing appropriate services is a willingness to integrate health and social care into a holistic approach that also involves the family and community. The resources of the community may be difficult to gather, but community health workers who have more knowledge about these things can often be accessed. The concept of going alone to the doctor is quite foreign to many cultures and so the whole consultation will often be done in the

context of family. However it is very important to try at some stage to see the patient alone, as the family can be part of the problem, as well as part of the solution.

8. How will we know when you are well again?

Doctors tend to ask this question of themselves, if not of their patients, as they assess their progress. However, in a transcultural setting it is important to hear whether or not the patient is really expecting a solution to, for example, their back pain. It may be that at some level they are aware that there is another problem underlying their presenting complaint, and that they are aiming to be feeling well enough to laugh with their grandchildren and have a good night's sleep. The concept of life-long medication for chronic diseases and that medication cannot 'cure' illness but only 'treat' it, is also something that can be very confusing. Many are concerned that the continued need for medication over a long period of time implies addiction and so give themselves 'breaks' or try to decrease the dose.

9. When would you like to come back?

If a trusting relationship has been built, the solution has been acceptable and well communicated and the aims of treatment agreed upon, it may be left up to the doctor to suggest a realistic timeframe. However the patient's insecurity about their illness may lead them to suggest an earlier time and if possible this should be accommodated. The issues dealt with in the initial consultation may give a deeper insight and confidence for both parties and further appointments will continue the assessment or treatment with a more collaborative association. On the other hand it is not uncommon for patients to have an almost 'magical' view of medication and they may take only a short course and expect that they won't need to return.

In asking questions in this way, it is likely the patient's self-esteem will be enhanced and the 'therapeutic alliance is strengthened when the patient recognises that you are genuinely interested in their country and culture of origin' (Barrett, 2001). As the practitioner, it is important to try to change the approach with the patient, not necessarily the view of the illness. Keeping social, cultural and spiritual issues in

the forefront of one's view of diagnosis and treatment can be quite a juggling act, but can lead to a way of relating that is more acceptable for patients without sacrificing the doctor's own integrity. 'Direct questioning and discovery of the core issues for each individual is the best approach when dealing with cultural influence rather than maintaining lists of cultural characteristics of different ethnic groups' (Seah et al., 2002). Ultimately, what is required is a mutually interpretable explanation for the patient's presenting problems.

Current therapies

Cognitive Behaviour Therapy, useful in many consultations with depressed patients, may not be useful in some cultures as 'cognition' is very much culturally mediated. It has been suggested that by stepping inside the private world to understand the feelings and personal meanings that a patient is experiencing may be too intrusive or offensive in some cultures.

Narrative therapy as a means of helping patients move on from their depression concentrates on helping patients gain a sense of control over their lives, both internally and externally, as the main therapeutic goal. Often people with depression from any culture portray themselves as 'passive victims'. Part of recovery can be in helping them to move their problems to the 'outside', locating their success in surviving internally (Boje, 1999). Even in a busy practice, questions can be asked about the skills distressed patients have previously used to survive and the practitioner can help them to access those skills in other situations so that they can increase self-responsibility and empowerment. This will help build a healthy internal resilience and locus of control to cope with problems. In most cultures this resilience is enhanced if there has been a healthy childhood history, adaptive style, a strong faith, sense of humour and strong sense of personal identity (Benson, 2003).

Narrative therapy was identified by Aboriginal health workers in different parts of Australia as more appropriate to Aboriginal culture than the more conventional Western mental health approaches. 'In Western culture there is a dominant story about what it means to be a person of moral worth. This story emphasises self-possession, self-containment, self-

actualisation and so on. It stresses individuality at the expense of community and independence at the expense of connection. These are culturally specific values which are presented as universal, "human" attributes to be striven for. The attempt to live up to these dominant prescriptions can have profoundly negative consequences for people's lives' (Aboriginal Health Council of South Australia, 1995). Narrative therapy helps authenticate and strengthen the preferred stories about reclaiming Aboriginal knowledge, spirituality and way of life in the face of the 'dominant' culture (Boje, 1999).

Conclusion

The split between social, cultural, psychological and physical concepts of medicine is narrowing as new evidence emerges which suggests that social and cultural issues become part of the neurophysiological makeup, and the neurogenesis that occurs with the use of both medication and psychotherapy can be mapped using scanning techniques. Doctors need to have the knowledge and ability to use appropriate cultural as well as medical diagnostic skills to guide treatment, as mistakes can be made without taking the time to respond effectively to linguistic, cultural or psychosocial concerns. Reflective questioning, exploration of beliefs and fears, respect for differences in perception, clear explanations and proactive follow-up are all part of being interested in the person as well as the illness.

If patients feel their beliefs, values, and practices are understood and respected by the practitioner, there is an increased likelihood a good relationship will be established and the patient will trust the doctor and the clinical procedures. Cultural sensitivity in consultations is ultimately about the same parameters that make for good practitioners in any situation – self-awareness, rapport, evidence-based medicine, health promotion, respect, collaboration and good communication. Keeping these values in mind will ensure that a strong therapeutic alliance will develop with more successful outcomes for both doctor and patient.

Note

This paper was originally prepared as part of the author's role as the Australian representative on the WONCA (World Organisation of Family Physicians)

Special Interest Group in Psychiatry and Neurology, as a submission to the development of the *Culturally Sensitive Depression Guideline* (see http://www.globalfamilydoctor.com/aboutWonca/sig/FinalguidelinedepressionSIG_Version1.0.pdf).

References

- Aboriginal Health Council of South Australia (1995). Reclaiming our stories, reclaiming our lives: An initiative of the Aboriginal Health Council of South Australia. *Dulwich Centre Newsletter*, 1, 1-40.
- American Medical Student Association (2004). *Cultural Competency in Medicine*. Available at <http://www.amsa.org/programs/gpit/cultural.cfm>
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR* (4th edition). Washington, DC: APA.
- Australian Bureau of Statistics and Australian Institute of Health and Welfare (2003). *The Health and Welfare of Australia's Aboriginal and Torres Strait Island Peoples*. Canberra: ABS and AIHW.
- Barrett, R. (2001). *An Introduction to Sociocultural Psychiatry*. (Postgraduate Course in Psychiatry - New South Wales Institute of Psychiatry). Sydney: NSW Institute of Psychiatry.
- Benson, J. (2003). Third culture personalities and the integration of refugees into our community. *Synergy*, 2003(2), 3-4, 20-21. Available online at www.mmha.org.au/MMHAPublications/Synergy/2003_No2/view
- Boje, D.M. (1999). *Narrative Therapy*. <http://cbae.nmsu.edu/~dboje/narrativetherapy.html>
- Columbia Encyclopedia* (6th edition). (2001). New York: Columbia University Press.
- Geertz, C. (1985). *The Uses of Diversity*. (Tanner Lecture on Human Values delivered at The University of Michigan, November 8, 1985.) <http://www.tannerlectures.utah.edu/lectures/geertz86.pdf>
- Kleinman, A. & Good, B. (Eds.) (1985). *Culture and Depression. Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder*. Berkeley: University of California Press.
- Knowlton, L. (2001). PET scans compare effects of drug treatment and talk therapy. *Psychiatric Times*, 18(7), <http://psychiatrictimes.com/p010744.html>
- National Institute of Mental Health (2004). Press release about Gogtay, N., Giedd, J., Lusk, L., Hatashi, K., Greenstein, D., Vaituzis, A., Herman, D., Nugent, T., Clasen, L., Toga, A., Rapoport, J. & Thompson, P. (1984). Dynamic mapping of human cortical development during childhood through early adulthood. *Proceedings of the National Academy of*

Sciences, 101(21), 8174-8179. (accessed online August, 2004)

<http://www.loni.ucla.edu/~thompson/DEVEL/PR.html>

Seah, E., Tilbury, F., Wright, B., Rooney, R., & Jayasuriya, P. (2002). *Cultural Awareness Tool: Understanding Cultural Diversity in Mental Health*. (accessed online June 2003)

<http://www.mmha.org.au/MMHAPublications/Store/cat.pdf>

Shweder, R.A. & Bourne, E.J. (1984). Does the concept of the person vary? In R.A. Shweder & R.A. LeVine (Eds.), *Culture Theory*. Cambridge: Cambridge University Press.

Thakker, J. & Ward, T. (1998). Culture and classification: The cross-cultural application of the DSM-IV. *Clinical Psychology Review*, 18(5), 501-529.

Wakefield, J. (1992). Disorder as harmful dysfunction: A conceptual critique of DSM-III-R's definition of mental disorder. *Psychological Review*, 99(2), 232-247.

Watters, C. (1999). The need for understanding. *Health Matters*, 39, 12-13. (accessed online October 2003)

www.healthmatters.org.uk/issue39/needforunderstanding

World Health Organization (1986). *Ottawa Charter for Health Promotion*. (Charter adopted at the First International Conference on Health Promotion, Ottawa, Ontario, Canada). (accessed online 15 August, 2004)

http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf