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Editorial

Cultural Aspects on Psychiatric Illnesses among Immigrants

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Editorial

During the last two decades or so, groups of immigrant patients in Western mental hospitals have challenged traditional psychiatry and questioned the ways immigrant patients have been treated.

One question that has been raised, is whether or not cultural differences between the patient's understanding of his/her illness is in accordance with the description of his/her disease, constructed by medical and nursing staff members.

The concept of illness has been related to the patient´s subjective suffering and spontaneous explanation of his sickness. To conceptualise it in this way, would automatically imply an openness towards the possibility that psychobiological conditions, which traditionally are thought to be universal, may in fact be culturally coloured by the patient´s experiences of such an illness in his/her homeland.

A similar concept of disease has been related to the doctor´s explanatory models, developed within his/her biomedical, scientific Western culture, including specific conceptions of symptoms, treatment, prognosis etc. [1].

Nevertheless, I am arguing that cultural differences may clash intensely inside the glass house of a doctor-patient relation, leaving the patient behind with a feeling of being an inferior, misunderstood or neglected deviant in his host country.

The sociological approach to a comprehension of the gap between immigrant patient's explanations of their failure to integrate successfully in their host societies, and the labelling of these patients as deviants by medical and nursing staff members or by any ´significant others, are one of the major issues.

Cultural aspects of psychiatric illness among immigrants cover a variety of practical and academic approaches to a field that has been neglected for many years in the history of psychiatry. It would, however, be rather unfair to say that these approaches are all new, even though it is a fact that most of the studies have been carried out during the last three decades.

Bagley [2] claims that rates of schizophrenia is relatively stable between cultures. In other words, it does not seem like immigrants are more susceptible to a special types of illnesses compared with native-born patients. Cochrane and Singh Bal [3] claimed that classical schizophrenia is held to be an endogenous and insidious disorder, which is unlikely to be provoked by stress in those who are not already vulnerable. Thus it is likely that a combination of different factors increases the frequency of the diagnosis of schizophrenia amongst immigrants: stressful post-migration, schizophrenia predisposes people to migrate, and misdiagnoses of schizophrenia that are possible in some ethnic groups in their new country.

Among European psychiatrists, non-Europeans patients were initially believed to have bizarre and incomprehensible mental illness. It could be that the high rate of schizophrenia really means little more than poor communication between patient and doctor. "Perhaps the mental patient does not have a distorted relationship with reality so much as an inability to present his experiences and difficulties to the psychiatrist in a form the latter can understand?"[4].

Traditionally, psychiatrists have approached mental illness through various versions of methodology, causal explanations, modes of treatment etc. Many of these approaches to psychiatry have, expressed it in a simplified way, been occupied with the patient as an individual, his/her life-story, his/her growing up conditions, his/her mental pre-dispositions to specific mental disorders, his/her emotional reactions to traumatic incidents etc. The focus has been on "the clinical pattern of illness observed in the individual patient without any understanding of its possible social determinants. An emphasis on hospitalized patients, but not on distress as experienced in the community" [4].

Cross-cultural psychiatry emphasizes more thoroughly the effect of migration and of social change with regard to the patient's illness. Thus, Leighton has suggested that rapid social change results in a social non-equilibrium and disintegration; when such change occurs there may be, for example, increasing poverty, cultural confusion, secularization, high frequency of broken homes, few and week leaders, and fragmented networks of communication. This may in turn result in alienation, unmet personal needs and higher rates of mental illness in those who cannot or do not "fit" into the new society. Thus, as societies shift, under economic and other pressure, from traditional village systems to urbanized and industrialized systems, more people come to be "at risk" for psychiatric disease. Social non-equilibrium, through an intervening process of disrupted personal needs, causes mental illness [5].

One may argue that one reason why so many patients are cured in peasant societies, and not in modern societies, is simply due to the fact that the range of normal behaviour is much wider than it is in modern Western societies. One may also argue that in Western societies behaviour must meet higher standards in order for the patient to be judged cured [5]. Waxler makes the assumption that different societies do not cause differences in rates of mental disorder. In contrast, she offers the so called labelling theory of deviance (or: a social response explanation), that provide concepts and hypotheses that help to explain how different societies succeed in moulding the mentally ill person to match with the social expectations.

Waxler, of course, does not intend to ignore any clinical or bodily symptoms that may occur, but she draws a conceptual distinction between clinical diagnosis and social role since, she argues, "it is quite apparent that some clinically ill people are never defined by anyone as being sick and some sick people have few, if any, clinical symptoms" [5].

Two more aspects of the labelling theory should be mentioned.

"We all know", Waxler says, "of instances in which a high status person´s deviant behaviour is "normalised", or perhaps reinterpreted as eccentricity, while the same behaviour in a low status person is labelled and treated as mental illness. We know, too, that the social class of the patient relative to the doctor is related to the diagnosis and prognosis the psychiatrist gives. Those lower class patients who receive more serious diagnoses are also very likely to receive messages confirming their illness that they cannot resist [5].

Thus, Wax ell sums up, "social expectations are powerful forces and we should not be surprised to find the significant and perhaps primary part they have in moulding the psychiatric patient´s career" [5].

Since immigrant patients are not be familiar with Norwegian culture in general, and not with the Norwegian health care system in particular, we might assume that cultural differences will lead to a labelling of the patient that in some cases would differ from a labelling in his home country, and even contribute to the weakening of his position in his host country.

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