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FEATURE ARTICLE

Mental health nursing and cultural diversity

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ABSTRACT: *The focus of this article is on ethnic cultural difference. The establishment of a bi-cultural model of health care delivery has been a recent priority in New Zealand. Bi-culturalism has become an important concept for Maori and Pakeha (Europeans), working in partnership in the planning and implementation of mental health services in New Zealand. Adoption of the principles of respect and recognition of the uniqueness of different cultural identities, by nurses, has meant that clients who use mental health services in New Zealand are beginning to benefit from nursing care that is culturally competent.*

KEYWORDS: *bi-culturalism, communication, cultural diversity, stereotypes.*

INTRODUCTION

Mental health nursing is beginning to recognise the impact different behaviours, expectations and beliefs held by individuals and communities from a diversity of cultural backgrounds, will have on the assessment, management and treatment options offered to mental health clientele. There is an expectation that when an individual enters the mental health system they submit to a biopsychiatric, eurocentric philosophy of health, illness and care delivery (Bickley, 1987; Capra, 1982; Ferguson, 1980; Hughes, 1993; Ramsden, 1990). However, this means that the relationship between culture, health practices and illness presentations in assessments are overlooked risking not only misdiagnosis, but also inappropriate treatments (Campinha-Bacote, 1997). Although there are many aspects that constitute culture other than ethnicity, for example, gender, religion, sexual orientation, socio-economic and occupational groupings, the focus of this article will be on ethnic cultural difference. In New Zealand the first priority has been the establishment of a bi-cultural model of health care delivery. Bi-culturalism has become a significant concept with Maori and Pakeha (Europeans), working in partnership in the planning and implementation of mental health services. With the principles of respect and recognition of the uniqueness of different cultural identities as the cornerstones of bi-cultural mental health nursing (Ramsden, 1990; Wood & Schwass, 1993), clients who use mental health services in New Zealand are beginning to benefit from nursing care that is culturally competent.

CULTURE, TREATMENTS AND MENTAL ILLNESS

A number of studies have explored the relationship between culture and psychiatric treatment

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outcomes. Over the past twenty years several studies have focused on the genetic differences of diverse ethnic groups and have found that different genetic populations experience the effects of psychotropic drugs differently (Campinha-Bacote, 1997; Hughes, 1993; Lin, Anderson, & Poland, 1995; Oakley, 1998; Takahashi, 1989). Because most psychotropic drugs have been trialled on males of European extraction, drug concentrations and recommended dosages are titrated to suit their genetic make up (Campinha-Bacote, 1997; Takahashi, 1989). However, non-Caucasian people and women, experience the effects of pharmacological interventions differently, and can be more susceptible to the toxic effects of these drugs (Campinha-Bacote, 1991; Lin *et al.*, 1995; Oakley, 1998; Speight, Myers, Cox & Highlen, 1991). For example, while about 9% of Europeans are identified as 'slow metabolisers', with Asians this is up to 32%, thus greatly increasing the potential for extrapyramidal symptoms in clients of Asian extraction (Campinha-Bacote, 1997). Clozapine, which is associated with agranulocytosis in 1% of the general population, is linked to agranulocytosis in up to 20% of Jewish people treated (Campinha-Bacote, 1997). Tricyclics have been found to produce side-effects in Hispanic clients at half the usual dose (Campinha-Bacote, 1997), while standard dosages produce better than average responses in African-American clients (Oakley, 1998). Because women secrete up to 40% less stomach acid than men, drugs such as the benzodiazepines and tricyclic antidepressants, will have a higher percentage absorbed into the system before being neutralised by stomach acid. There is thus a need to consider both the ethnic group and gender of clients when deciding on type and dose of medication, and observing for side effects (Oakley, 1998).

Although the effects of pharmacological interventions can be scientifically tested for, and differences in body size, composition and metabolic rates accounted for, less is known about the effects of psychosocial factors that may influence compliance rates or treatment outcomes (Cooney, 1994; Flaskerud, 1990; Kuo & Kavanagh, 1994; Westermyer, 1985). Psychological factors such as feeling understood by nursing staff, the involvement of family or community supports, acknowledgment of cultural influences, and collaboration in the planning of care, can have a major impact on the success rates of interventions (Campinha-Bacote, 1997; Oakley, 1998; Wright, 1991). This is particularly important when clients are continuing to use other remedies that may interact with prescribed medications. Clients need to be able to disclose this information as there can be interactions with prescription drugs which reduce the therapeutic impact of either medication, or unwelcome interaction effects may cause clients to stop prescribed medications altogether (Campinha-Bacote, 1997; Oakley, 1998). In addition, some cultural practices employ physical treatment options which might be interpreted as physically or mentally abusive by other cultures. These treatments need to be understood and catered for within the health care environment (Oakley, 1998; Simons & Hughes, 1993).

Some research has focused on the influence of culture on treatment choices and diagnostic preferences of Western-based mental health services. This research found that clients from a culture other than the clinician were more likely to be prescribed for, and given an Axis I diagnosis, than clients who shared the culture of the clinician (Lin *et al.*, 1995). The effect of diagnostic labelling and treatment options is compounded when those assessing and treating clients do not have a shared language with the client or the family. There have been a number of studies undertaken to explore the effects that language difference and the impact the use of interpreters has on assessments, treatments and outcomes (Berg & Jaya, 1993; Flaskerud, 1990; Kim, 1995; Marcos, 1979; Sue & Sue, 1990; Takahashi, 1989; Westermyer, 1985). It has been found that communication difficulties will often result in a diagnosis of more severe psychopathology (Flaskerud, 1990). One interesting piece of research which extensively reviewed the literature from both the United States and the United Kingdom found that both culture and social class influenced treatment choices, and that a shared cultural background or social status was more likely to result in the clinician offering psy-

chological treatments, whereas clients who did not share the clinician's background were more likely to receive non-psychological treatments such as medications (Wright, 1991). Since most psychotherapy tends to take place in outpatient settings, and physical treatments are more likely to involve hospitalisation, it could be concluded that clients from other cultures enter the mental health system at a significant disadvantage. Language differences have also been found to have a notable influence on treatment outcomes by decreasing the client's ability to interact with, or make self-disclosures to the clinician, reducing client–therapist rapport and restricting the therapist's ability to feel empathy, with resulting negative impacts on treatment compliance, and treatment choices (Hattar-Pollara & Meleis, 1995; Lin *et al.*, 1995).

The use of interpreters in assessment and treatment has also been found to be problematic as interpreters can omit information, substitute their own interpretations on both questions and answers, change the focus of questions, or even normalise the client's answers because of a lack of psychiatric knowledge or a desire to minimise the presenting psychopathology (Flaskerud, 1990). As with client–therapist interactions, different educational and social standings of the client and interpreter have been found to affect communication styles and understanding, thus the information supplied to the clinician may be skewed by these unseen influences (Kim, 1995; Marcos, 1979). Similar difficulties can be encountered when using interpreters in the therapy sessions, making bilingual supervisors and video taped sessions to ensure interpreter reliability, a necessity (Baxter & Cheng, 1996).

Because most styles of psychotherapy are derived from a white, middle class stance, there have been doubts expressed that therapy can be in any way applicable to non-Western clients (Flaskerud, 1990; Wilkins, 1993). Also criticised as being culturally unsound is the art of family therapy which has been cited as a mono-cultural therapy style which does not address the different significance and communication styles families and communities hold in non-Western societies (Campinha-Bacote, 1997; Pare, 1995). Likewise the use of diagnostic assessment tools is also shrouded in controversy (Campinha-Bacote, 1995; Kuo & Kavanagh, 1994; McGee, 1994; Rosenbaum, 1989). Diagnostic and personality tests have historically been devised by and for Caucasian, middle-class participants, and even when translated and revised, they may still not address differences in cultural perceptions of what is normal behaviour and what is defined as mental illness (Flaskerud, 1990). In 1994, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* contained for the first time information about cultural variance and also included an appendix reference to culture-bound illnesses and cultural assessment information. This indicates a major shift in both the acknowledgment of the influence of culture on mental illness presentations, and in the possible treatment options adopted by mental health services (Campinha-Bacote, 1997).

CULTURE, CARE AND NURSING

Nurses have been thinking about and writing about cultural care issues for many years. Madeleine Leininger is the most widely acknowledged expert in the field of transcultural nursing. She first began studying cultural difference and health care in the 1940s (Reynolds & Leininger, 1993), and over the years has developed and refined the concepts of 'Cultural Care Diversity and Universality' theory of nursing practice, which has been subsequently dubbed the 'Sunrise Model'. In her theory, Leininger identifies the influence of such things as values, education, economics, religion, environment, and language on an individual's existing patterns of health care and articulates the interactions between these, the health system, and nursing interventions (Reynolds & Leininger, 1993). She also edits the *Journal of Transcultural Nursing* which supports the sharing of experiences, debate, and research in the fields of culture, ethnicity and transcultural health care. Nursing education tends to socialise nurses into the biomedical paradigm which does not explicitly address the question of culture or the influence culture has on an individual's response to health

issues (Capra, 1982; Ferguson, 1980; Hughes, 1993; Rosenbaum, 1989). However, nurses are ideally placed to foster an understanding of the different ways cultures define and understand what constitutes normal and abnormal, illness and wellness, and what are viewed as reputable treatment options by each client (Campinha-Bacote, 1994a; Leininger, 1993). In some cultures, illnesses such as depression can initially present as a physiological problem rather than a psychological problem. Thus, there is a risk of misdiagnosing the illness or of the person's mental health deteriorating as they wait longer for assistance than someone who presents their distress in a manner and language to which health professionals are accustomed.

It is important to recognise that we are all part of many cultural heritages. Our values and belief systems make each of us diverse within our own culture and thus unique (Campinha-Bacote, 1994b; Habayeb, 1995). Health care systems can also be understood as cultures. Health professionals' techniques, professional boundaries and language all contribute to making a cultural phenomenon which to the uninitiated can be both confusing and frightening (Wright, 1991). There is some debate as to whether culture should be explored as a distinct aspect of nursing practice or addressed within concepts such as holistic nursing or psychosocial considerations (Davis, 1986; Flaskerud, 1990; Germain, 1992; Oakley, 1998). Many argue in favour of a distinct educational process addressing the issue of cultural difference, believing that if we have a working knowledge of other cultures then we are more likely to have a positive influence on the treatment outcomes of individuals from other cultures who present with mental health problems (Campinha-Bacote, 1995; Cooney, 1994; Kim, 1995; Leininger, 1993; Orque, Bloch & Monroy, 1983; Sawyer *et al.*, 1995). However, textbook knowledge alone is not enough, and care based on cultural stereotypes may do more harm than good as there are risks in focusing on cultural stereotypes. For example, we may lose sight of the individual's needs and uniqueness, or we may attempt to impose our understanding of how we believe they should behave according to our stereotyped understanding (Donnelly, 1995; Kim, 1995). Opponents to the idea of explicit cultural education argue that if we are unable to work with clients from other cultures without using 'recipe book' descriptions because they are different, then how can we work with any clients, who by the very nature of being human, are different (Orque *et al.*, 1983; Spreight *et al.*, 1991).

Nurses are taught about the cultural shock which can affect any client on entering the health care system. Similarly, nurses are also encouraged to refrain from using jargon when talking with clients, to listen to and to advocate for them, and to respect client's individuality and the right to be different. However, all too often cultural differences are referred to in pejorative terms when clients' culturally bound health practices are discussed. For instance, terms such as 'third world', 'primitive', 'folk remedy', 'superstitious' and 'medicine man' are used in association with those who are culturally different, while culturally familiar health practices and services are referred to as 'developed' or 'professional'! These words reflect our underlying beliefs and continue to support practices which can be ethnocentric (Campinha-Bacote, 1997; Heitman, 1992).

It is incumbent on mental health professionals to explore their own culture, to understand how this impacts on clients, and to research ways to accommodate difference within health care practices. Josepha Campinha-Bacote has been publishing articles about the influence cultural difference can have in mental health care settings since the early 1980s, and by 1994 had developed a framework for the delivery of culturally competent nursing care (Campinha-Bacote, 1994a). This framework requires that nurses who offer culturally competent nursing care first develop an understanding of their own culture, the culture of their working environment, and the dominant culture of the country in which they live (Davis, 1986). All persons are enculturated into the beliefs and values regarding family, school, occupation, and society; the culturally familiar is often deemed to be the 'best'. In nursing an adherence to the myth of cultural superiority can lead to communication breakdowns and clients being labelled as non-compliant, or uncooperative when they

display different understandings of health care interventions (Charonko, 1992; Leininger, 1993). Therefore, nursing interventions must include exploration of client's interpretation of events rather than just applying professional understandings. For example, while self determination and taking responsibility for oneself is a dominant theme in European cultures, many other cultures do not place the same value on personal autonomy. For some cultures, identity exists in relationship with others more than in relationship with the self. Introspection is not encouraged and decisions and problems are dealt with in a collective or communal way (Rothenburger, 1990; Wright, 1991).

Health care providers must recognise their own personal preferences, and prejudices, and those of the institutions in which they work (Campinha-Bacote, 1991). There must be a willingness to explore health care work from within the client's cultural context. It is important for nurses and other health professionals to develop an understanding not only of a client's health–illness beliefs, patterns, and health goals, but also an understanding of their own. Only by understanding one's own internalised system of values can we hope to avoid unknowingly attempting to impose these on others (Campinha-Bacote, 1995; Lowery, 1983). To be culturally competent with all clients, nurses must be prepared to dialogue and interact with all peoples. We must bring into consciousness our own assumptions, biases, thoughts and feelings regarding ourselves and others. We must have acquired an understanding of the validity of other viewpoints and beliefs. We must be prepared and able to enter the other's world and view events through their eyes. And finally, we must integrate all of this into our everyday practice.

CONCLUSION

Much that is written about culturally competent nursing reflects a need to acknowledge difference and work carefully with clients from other cultures because of the potential for cultural imposition, and therefore poor client outcomes. Cultural assessment techniques encourage nurses to ask open-ended questions, acknowledge different health and illness styles, and to ensure involvement of as many family members as the client wishes. Certainly, the difficulties inherent in working with clients who do not speak English as a first language require special attention and, within the field of mental health, the provision of qualified professionals who do speak other languages would appear to be the most successful way to ensure that competent diagnosis and treatments can be delivered. Importantly, when working with clients from non-Caucasian ethnic backgrounds, nurses need to be alert to the potential danger presented by different reactions and susceptibility to side effects when clients are receiving pharmacological treatments, and the hazards inherent in using diagnostic tools which were not written for, or trialled on that client's cultural group.

Of the health professions, nursing has the most intimate client contact and is frequently responsible for gathering information. As such, it is important that care be taken to ensure that mono-cultural understandings and beliefs are not imposed inappropriately, especially when clients are culturally different. If mental health nursing care is to be culturally sensitive, this requires an awareness of the possible misunderstandings that all clients may face as they enter the culture of the mental health system, and a willingness to work with each individual to achieve mutually agreed outcomes.

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