R3G.1

INFORMATION SHEET:
Culture and Mental Illness

GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

A person's understanding and beliefs about mental illness are strongly related to their wider cultural health beliefs. "In studying the relationship between ethnicity and conceptions of mental distress, anthropologists have shown how people from different cultures explain mental distress and how these 'explanatory models of distress' influence causal attribution and presentation of a disorder as well as patterns of help-seeking." (Sheikh and Furnham, 2000).

Anthropologists (Landy, 1977, Furnham, 1999, Kleinman, 1987) state that most societies attribute their distresses to both natural and supernatural causes. Non-western societies in general associate the aetiologies of mental distress to social and supernatural phenomena, while natural or more patient-centred explanations of distress are more common in the Western industrialised world.

Feelings of depression are experienced by all people and are a normal component of disappointment and grief. Depression may be a symptom of a mental disorder (such as bipolar disorder, an anxiety disorder, or schizophrenia) or of other medical diseases, ranging from diabetes and thyroid disorders to post viral syndromes. However, the way depression is dealt with, talked about and managed varies among cultural groups and cultural meanings and practices shape its course. "Culture influences the experience of symptoms, the idioms used to report them, decisions about treatment, doctor-patient interactions, the likelihood of outcomes such as suicide, and the practice of professionals" (Kleinman, 2004).

Kleinman uses the example of many parts of Chinese society where depression is expressed as feelings of boredom, discomfort, inner pressure, and symptoms of pain, dizziness and fatigue rather than feeling sad. A diagnosis of depression is deemed morally unacceptable due to the **stigma** associated with depression. Naeem and his colleagues (2006) agreed with the literature from western European societies that in most societies some supernatural, religious, moralistic and magical approaches to illness and behaviour exist. Their study focussed on the stigma attached to mental illness among medical students and doctors in **Pakistan**.

Even though most medical students and doctors follow medical textbooks published in the west, the results from their study with 294 participants revealed that doctors and medical students held negative attitudes towards people with schizophrenia, alcohol and drug problems as they were perceived as dangerous, unpredictable, difficult to communicate with and they looked different. Negative attitudes were also observed towards those with depression as they were viewed as unpredictable, difficult to talk to, unable to pull themselves together and have only themselves to blame.

A study of "Beliefs and attitudes towards mental health among medical professionals in **Delhi**" conducted by Kishore et al in 2007 found that only about 60% of respondents considered mental illness to be a disease. Nearly 80% of the respondents considered psychiatry to be a difficult discipline. Mental illness is still a stigma as a high percentage of the resident doctors wanted psychiatry to be separated from total health care and catered for in separate setups. Stigmatisation of patients with

mental illness was reflected in 63% of respondents who said they would not employ a person who has recovered from mental illness and 45% would be against a close relative marrying such a person.

They concluded that these attitudes reflected inaccurate or incomplete knowledge and there is a need for increased teaching about mental health issues across specialty boundaries during medical school. Mental health in India has been largely ignored with a paucity of trained mental health professionals and "the presence of myths and misconceptions among medical professionals."

A combined study conducted by Monash University and GP primary care in **Abu Dhabi** (McCall and Saeed, 2006) sought to explore General Practitioners' knowledge and attitude towards anxiety and depression in Abu Dhabi. About 50% of the General Practitioners working in Abu Dhabi come from Arab countries (North Africa and Middle east) while the other 50% are from the Indian subcontinent (India, Pakistan and Bangladesh). The results of the attitude section of the study showed that although GPs feel that they can make a difference to patients with anxiety and depression, they don't consider it to be a major role and these patients should be managed by a psychiatrist. One third of respondents felt frustrated when exploring psychological issues which could be explained by a strong biomedical approach in training. More than half the knowledge questions were answered incorrectly by 50% or more of the GPs. Low scores were recorded on:

- different types of anxiety,
- causes of hallucination,
- general features phobia,
- presentation of obsessions in obsessive compulsive disorders
- assessing degree of depression and drugs that may cause it
- depression in the elderly and postpartum depression
- factors which may increase suicidal attempts
- differentiation between depression and anorexia nervosa
- differentiation between depression and drugs which interact significantly with tricyclic antidepressants

In comparison, McCall's study showed that GPs in Australia had a good knowledge level and 86.9% of respondents answered the knowledge questions correctly before attending a course in psychiatry.

The authors concluded that "GPs in Abu Dhabi lack important knowledge, which is needed for recognition and management of anxiety and depression… This means that a large proportion of patients suffering from anxiety and depression, who attend primary care clinics, will not be recognised and therefore do not get the required treatment."

There are not many published studies on doctors' attitudes and knowledge about mental health in non-western countries. From the limited data available it is possible that International Medical Graduates from non-western countries, even though they

received training in English and use western texts, may lack knowledge, experience and confidence when dealing with mental health issues. They will have developed cultural beliefs about mental illness which may be different from cultures in Australia.

Supervisors need to raise this issue with their registrars, engage in exploration of their attitudes to mental health and offer suggestions for training in order to meet the learning needs of the registrar and upgrade their skills.

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