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# Cross-cultural psychiatric assessment

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Different cultures vary in their perceptions of mental illness (Karno & Edgerton, 1969), which can affect their utilisation of orthodox psychiatric facilities (Padilla *et al*, 1975; Sue, 1977). Mental health services may be seen by ethnic minorities as challenging the value of traditional support systems, reflecting dominant Western cultural values and harbouring implicitly racist psychological formulations. The clinician–patient interaction may become fraught with misunderstandings if the two parties come from different cultural backgrounds and bring distinct cultural expectations to the encounter.

The concept of a core disease process with concentric rings of illness behaviour is a useful one, allowing the clinician to make sense of a diversity of surface phenomena which may all be related to a narrower range of disease categories. Thus, while the patient suffers from an ‘illness’, the clinician diagnoses and treats a ‘disease’ (Eisenberg, 1977; Kleinman, 1980). Yet classifications of illness vary across cultures, and individuals often carry such categories with them and use them to make sense of altered functioning. The clinician must identify whether a specific cluster of symptoms, signs and behavioural changes that are demonstrated by the patient are also interpreted consistently by them and their relatives, and how their personalised diagnostic models fit in with the psychiatric models.

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## Culture and mental illness

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Culture can influence mental illness by defining the normal and the abnormal, by implicating domains of aetiological factors, by influencing the clinical presentation and by determining help-seeking behaviour. Cultural mechanisms can provide social support, socially acceptable emotional outlets,

cathartic strategies and synchronisation of individual differences, which combine to give a meaningful and consistent world view. Such cultural determinants operate as much within the doctors’ field of communication as among patients. The doctor–patient interaction is affected by the training, past experience, social class and ethnicity of the doctor and by the past experiences, educational and social background and ethnicity of the patient, as well as by shared and non-shared aspects of the economic and political climate. Gender, socio-economic or educational status, lifestyle, job or professional role may overshadow the racial identity of the patient as communication barriers; if cultural variables are over-emphasised, the provider is guilty of stereotyping the patient, while if racial considerations are under-emphasised, the doctor is guilty of insensitivity to influences that may affect the dynamics of the interview (Pederson & Lefley, 1986).

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## Cross-cultural competency

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Sue (1981) has proposed that minimal cross-cultural competency for counsellors lies in three spheres (which are equally applicable to clinicians). First, beliefs and attitudinal competency of the doctor, including an awareness of his or her own cultural heritage, biases and values, feeling comfortable with differences in relationships and acknowledgement of the value of the patient’s own culturally consistent support structures. Second, knowledge competency: the doctor must understand the social structure of minority groups, possess adequate cultural knowledge about his or her clients, be competent in generic skills and be aware of institutional barriers that patients encounter. Third, skills competency, including a wide repertoire of verbal and non-verbal responses, and the ability to send and receive verbal and non-verbal messages accurately and

appropriately, and exercise institutional intervention skills to change the constellation of existing systems of care when they might be inappropriate. Similar skills should be nurtured by those wishing to improve communication with all their patients.

## Psychiatric assessment

Assessment interviews should be used as the starting point for understanding a patient's distress, and for developing a collaborative therapeutic relationship. However, it is not uncommon that a diagnosis is seen as a final stage in the consultation process. Linguistic difficulties compounded by uncertainty about the idioms of distress, coupled with time restrictions and the quick application of the bio-medical models the clinician is used to, may lead to inappropriate conclusions being reached. Some patients (whether for reasons of ethnicity or otherwise) will require a longer assessment before a comprehensive management plan can be formulated that represents the optimal intervention for that particular patient.

### Box 1. Setting up the assessment

Scrutinise your limits of competency  
 Acknowledge how your skills can be blunted or affected by your culture  
 Attend to the patient's limitations  
 Know the predominant group  
 Know the patient's skills and strengths  
 Know the family's limits – their language limitations, sense of urgency, realistic capacity to cope and coping strategies available to them  
 Explore the family's skills and strengths – do not denigrate these if they appear idiosyncratic  
 Explore the interpreter's role, skills and limitations: meet before the assessment to identify their knowledge of culture; identify sources of difference (e.g. dialect, tribe, religion, island); agree on the method of joint working (e.g. literal translation or use of interpreter to orientate cultural context of complaints)  
 Patients' and their families' objections to that particular interpreter should be elicited  
 Explain that total confidentiality will be observed

The principles of quality consultation have been described from a multitude of theoretical frameworks (see Pederson & Lefley, 1986; Fuller & Toon, 1988). An optimal assessment requires special attention to several contextual factors.

### *Communication and cultural distance*

The principles outlined here are general guidelines for safe and sensitive practice. Before starting an assessment, it is important to find out about the patient's culture, including taboos, rites of passage and religious values. The language in which the patient prefers to communicate must first be identified. If this is not English, an interpreter must be identified who can advise on non-verbal communication as well as identifying idioms of distress and 'emotional' words used by the patient. For example, Gumperz *et al* (1982) have demonstrated clear differences in conversational styles of East Indian English and British English. The former was found to be context-based and the latter more individual. Thus, the fact that there is a common language does not necessarily mean that communication is adequate. An unstructured ten minutes of 'emotional orientation', during which idioms of distress and emotional words can be identified, will help to identify the direction in which the assessment must proceed (Box 1).

### *Essential historical data*

#### Adverse events

Do not assume that life events, adverse or otherwise, have the same significance for patients as they do for you or that they have only the significance described in the literature. Flexible enquiry will accurately elicit the impact of a patient's experiences. Separation from children, for example, may be more traumatic than you might imagine, perhaps with culturally unacceptable implications.

#### World view

World view is the way in which the clinician and the patient make sense of events, and varies depending on how the two individuals invest their worlds with meaning. As Sue (1981) has cautioned, the clinician or therapist is in danger of imposing or interpreting negatively the patient's world view if they are unaware of the basis for these differences.

Other foci of world view include group and individual identity and the patient's beliefs, values and cognitive perceptions of his or her distress and the help being offered. World view and identity can

be ascertained only after several semi-structured meetings with patients, family, advocates, and religious and community spokespersons as nominated by the patient. For example, the Black American or European world view includes African history and culture and the legacy of slavery and racism. Cheatham (1990) suggests that in Afro-centric culture the individual is emphasised only in terms of others, and this world view is, therefore, interdependent and holistic, oriented to collective survival. In addition, it emphasises an oral tradition, uses a 'being' time orientation (rather than a 'doing' one), emphasises a harmonious blending and cooperation, and stresses respect for certain roles, especially those of elders. A further example is given by Ivey *et al* (1993) who examined North American and Euro-centric views which divide the world into discrete 'knowable' parts, handle emotions carefully, focus on self-actualisation and independence as goals in life, are oriented towards a linear view of time and stress individuation and difference rather than collaboration. To expect patients from other cultures to fit into these norms is bound to create problems in assessment as well as management.

### Acculturation

No culture remains static. Increasingly, contact with other cultures inexorably shapes fresh cultural expectations and behaviour across generations. Acculturation must be seen as a multi-dimensional phenomenon which reflects the changes an individual goes through when he or she is exposed to a new culture. The emergence of a cultural identity, for example, is a complex process. In one model individual identity has been conceptualised as seven concentric equivalents of psychoanalytic structures, only some of which interact with society and culture (for details see Hsu, 1985). On the other hand, Jackson (1975) has put forward a five-stage theory for African-Americans in an attempt to explain the development of a 'culture consciousness':

- (a) naivety – the individual has no awareness of self, and the colour of their skin (ethnic or cultural identity) plays no role in their life;
- (b) acceptance – when personal identity is defined by the 'other' and can be passive or active and often creates conflict within one's self;
- (c) resistance and naming – where the individual identifies 'Black' self and its full meaning in the racist society and may feel angry and frustrated;
- (d) redefinition and reflection – when the main developmental task is to establish a firm African-American consciousness in its own right; and

- (e) a multi-perspective internalisation – when the individual *is* African-American and sees this with pride in self and awareness of the other.

Each of the five stages has an entry, adoption and exit place. Suffice it to say that an individual's identity is a complexity of inter-related definers of self, and group identity and is not readily discernible from the ethnic category applied. Acculturation can be explored by determining the period since migration and reasons for migration (see Box 2) and by focusing on areas of religious activity, preferred dietary patterns, preferred leisure activities and attitudes to traditional patterns of behaviour in the community (see Box 3). It is important to bear in mind that not all cultures can be pigeonholed into traditional Western European psychoanalytic models of self-identity, and individual experiences of migration and acculturation may not go through the same stages or at the same pace.

### Psychological/somatic mindedness

Too often, the label of somatisation is applied in a derogatory manner, especially if there is poor communication.

Although core depressive or psychotic symptoms are often regarded as universal, some see these constructs as disorders consistent merely with the developed world's conceptualisation of distress. Deep psychological reflection common in (parts of) the West appears to be relatively uncommon among the world's cultures and cannot be viewed on an evolutionary basis. India, for example, has a history of inner reflection which predates Western forms by millennia and which exhibits a depth and complexity that makes Western psychology look quite superficial, although it is found in theology and not (necessarily) the medical traditions (Leslie, 1977; Leslie & Young, 1992). In Japan, China or India, internal psychological

#### Box 2. Assessment of migration

How long ago migration occurred  
 Age of patient at the time  
 Motives for, difficulties in and preparedness for migration  
 Reversibility of migration  
 Differences between expectation and reality  
 Experiences before, during and after arrival  
 Migrated alone or in a group  
 Attitudes towards new country and culture  
 Helpfulness of the new society in adjustment  
 Previous similar experiences

**Box 3. Assessment of acculturation**

Religion – practice, frequency, who attends and where  
 Languages – which spoken where and with what frequency  
 Marriage/family – type, attitudes to marriage, responsibility at home, gender roles, arranged marriages  
 Employment – working with others of the same ethnicity, relationship to others at work, work ethic  
 Leisure activities – interests, languages spoken, films, music, preferences  
 Food – type, shopping, where?  
 Aspiration and attitudes to self

explanations of suffering are neither sought nor seen as credible (Kleinman, 1980; Reynolds, 1980; Shweder, 1991). Gaines (1995) suggests that somatic experiences and delusions may be more common in societies that do not psychologise distress, which is to say, most cultures of the world.

**Previous experiences**

Previous experiences with treatments and services give a clue to the future working within the therapeutic relationship. These experiences are as valid for the clinicians as for the patients themselves.

**Racism**

Patients from ethnic minorities are likely to have experienced discrimination in some fields of daily activity, whether it be open discrimination or suspected prejudicial treatment, on account of skin colour, religion, language, gender, race or other factors which may well be masked under a broader umbrella. One should not underestimate the impact of such events and invalid assumptions about their personal significance must be avoided. One should ask about such events in a careful, paced, sensitive manner so that the patient may respond accordingly. Even if perceived racist experiences do not directly contribute to the patient's presentation, such reports must be treated with respect; otherwise, the patient may find it difficult to trust the professional with more sensitive information.

**Microskills for the clinician**

Basic microskills for a clinician include those of attentive listening, influencing, focusing, confrontation and following of non-verbal cues. For patients

from some cultures, the body language of the clinician may be an early sign of the therapeutic encounter to be expected. It may be seen as intrusive, threatening or inviting. Eye-contact rituals and the significance attached to patterns of gaze avoidance can vary across cultures. The patient may expect evidence of understanding from the clinician and, if this is not clear, may respond in a way which may be perceived by the clinician to be unduly docile or aggressive (see Fuller & Toon, 1988).

***Limitations of standard mental state examination***

Where the patient does not share the mental health professional's culture (regardless of skin colour) then any symptoms and signs must be appraised critically in a cultural context and the appraisal revised in response to further information. Various cultural, religious and social groups are more likely to have different and possibly unique idioms of distress but to list them would suggest that clinicians could and should follow a recipe of cultural assessment based on the initial and perhaps erroneous impressions about the impact of cultural, religious and social differences. However, application of diagnostic processes without due attention to socio-cultural influences (and cultural context) is likely to meet with numerous pitfalls (Rack, 1982).

**Behaviour**

Behaviours which to the assessing clinician might appear odd may have a culturally sanctioned role (e.g. speaking in tongues, extreme religiosity, trance and possession). These phenomena can only be evaluated by carefully recording the behaviour, the patient's explanation for it, and the family and the cultural group's response to it. These views, if a sign of illness, may change as the patient recovers and become important signs by which the patients, their carers and others may in the future identify a relapse. Unusual behaviour which is not clearly understandable is too readily seen as evidence of psychosis without due attention to the adaptive or coping potential of the behaviour.

**Aggression**

One of the best documented gender differences is that males (particularly adolescents) consistently commit more aggressive acts than females do (Berry *et al*, 1992), men accounting for a disproportionate number of violent crimes in both industrial and developing nations (Goldstein, 1983). As Berry *et al* (1992) emphasise, cultural influences affect aggressive behaviour through

culturally mediated childhood experiences. Barry *et al* (1976) reported a gender difference in deliberate teaching and encouragement of aggression among children from a sample of nearly 150 societies. It has also been suggested that inter-gender identity developed by younger males because of almost exclusively female child-rearing is corrected either by severe male initiation ceremonies (Whiting *et al*, 1958) or by males asserting their manliness purely as a gender-making behaviour. Segall *et al* (1990) propose that hostility, conflict, frustration and anger are all inter-related constructs, but aggression is behaviour whereas frustration or anger are intent, and the two do not always go together. Aggression is also to be distinguished from assertiveness, the latter being more acceptable in some cultures. The aim here is not to discuss the possible aetiological models, but to emphasise that there are important cultural contributions to aggression which need to be taken on board in assessment.

Aggression is too often labelled as a manifestation of psychosis. Potential aggression is difficult to anticipate and the interviewer may err on the side of caution by intervening too early with control and restraint. Early intervention may well jeopardise any future treatment alliance. The only way to assess a potentially aggressive patient is from a position of security regarding one's own safety. Ensure you are accompanied and encourage a relative or friend of the patient to join you. There may be cultural norms of frustration, conflict resolution and aggression sanctions. Do not be prompted to anticipate an aggressive situation through your own fear of assault and uncertainty about a patient with whom you do not share cultural values, norms and mores.

### Hallucinations

Hallucinations are traditionally defined as perceptions which lack sufficient basis in external stimuli even though the patient places their origin in the outside world (Leff, 1988). Generally considered to be rare in normal people, Rees (1971) demonstrated that nearly half of bereaved individuals experience hallucinations of the dead person for years after the loss but this experience disappears as soon as the subject remembers that the other person is dead. In some cultures, this experience appears to have status value (Cheetham & Cheetham, 1976). Schwab (1977) reported that the young of lower socio-economic status and Blacks were more likely to report hallucinations. There was also a clear link with religious affiliation; among members of the Church of God one-fifth experienced hallucination, whereas none who belonged to the Jewish faith did.

It is clear that hallucinations and delusions (see below) must be judged in relation to the patient's

cultural milieu. The experiences of feeling ancestors' presence and hearing their voices or seeing them after their death are related to cultural norms and expectations. This also relates to concepts of self where the individual may perceive his or her existence in relation to other family or extended family members or the village (see Morris, 1994).

Hallucinations were found by Mukherjee *et al* (1983) to be more frequent in their Black sample than in the White group. Partly because of this, Blacks were more likely to be erroneously diagnosed as having schizophrenia in spite of a preponderance of affective symptoms. Ben-Tovim (1987) reported from his own experience in Botswana that it is possible to differentiate between auditory hallucinations (in their psychopathological significance) and culturally normal experiences by framing the right questions.

Hallucinations and paranoid thought may be understandable in some communities where victimisation or persecution in everyday life may be reflected in a cautious approach and suspicious attitude to strangers (including mental health professionals). The patient may not wish to reveal his or her true mental state; hence investment of time and repeated contact may be required before trust is established. Stress-induced psychoses may be the underlying cause of the symptoms and must be differentiated from schizophrenia (Rack, 1990). One should confirm exact experiences and consistency, and differentiate hallucinations from illusions and suggestibility states. If the patient uses figures of speech inexactly to articulate their illness experience, the clinician must avoid mistaking this for evidence of hallucination. Mukherjee *et al* (1983) demonstrated that among their Black sample with bipolar affective illness 85% had a previous diagnosis of schizophrenia and a higher than expected proportion had auditory hallucinations. The presence of visual phenomena is especially difficult to locate within the standard psychopathology framework (Al-Issa, 1995).

### Delusions

The traditional definition of delusion takes the role of culture and its context into account. As Rack (1990) emphasises, a cardinal rule of psychiatry is that a belief should not be classified as a delusion simply because it is erroneous; it must also be outside the range of normal beliefs for the culture to which the subject belongs. Appreciation of congruence with the patient's own culture is crucial in reaching a diagnosis; it is necessary to understand the culture within which individuals are embedded before deciding whether symptoms or beliefs are pathognomonic of underlying psychiatric disorder. There is some clinical evidence from the Caribbean suggesting that changing religions is often linked with

the onset of symptoms – the individual is searching for some level of stability or a haven which may tolerate eccentricities.

The form and content of delusions also need to be understood. The content is often derived from the patient's cultural milieu and is therefore most liable to be recognised as such by other members of his or her culture. Ben-Tovim (1987) has presented cases (mostly schizophrenics) from Botswana who were clearly seen as floridly mentally disturbed by their neighbours and other mental health professionals.

It has been argued that differences in cause of psychoses, especially schizophrenia, are due to subtypes of the illness. Social and cultural factors strongly influence responses to people who are ill and both directly and indirectly influence the course of illness (Waxler, 1977). Desjarlais *et al* (1995) proposed that where such an illness is considered an essential part of the self that cannot be expected to change (e.g. the schizophrenia as opposed to the patient with schizophrenia) it is more likely to be chronic. The support of the extended family linked with their concept of the patient's illness is likely to affect presentation, compliance and treatment. Thus an understanding of patients and their families' concepts of illness will be productive (see Box 4).

Delusions are associated with more than 75 distinct clinical pictures in the USA including schizophrenia, mania, paranoia, depression and others (see Gaines, 1995). Given the enormous variety and distinctiveness of ideas found in cultures across the world, the criteria by which distinctions are drawn are not easy to grasp (Gaines, 1995). The necessity of knowing the cultural context of the presenting ideation suggests that delusion must be externalised and communicated, it should be unshared and be 'incredible' in a native local context. The determination of delusion requires an internal cultural judgement. As Sims (1995) points out, patients believe their delusions literally and certain delusions may be more common than others, and since the definition is made by an external observer the evidence needs to be studied carefully.

It is unreasonable to expect the doctor to have an anthropological knowledge of all the belief systems likely to be encountered in a multicultural practice but the patient's family and advocates, community or voluntary organisations should provide sufficient sources. It is possible that if the examiner is not clear about the cultural values, then a delusional experience may be misattributed. Religious ideas, culturally sanctioned explanations, spiritual or cosmic explanations must be carefully identified and documented verbatim. Do not just

**Box 4. Suggested questions for explanatory models (modified from Kleinman, 1980)**

What do you call your concern/problem experience? What do others call it?  
 What is the cause of your trouble?  
 Why do you think it started (now) when it did?  
 How do your symptoms affect you and others around you? What problems do they cause?  
 How serious is your problem?  
 Do you think it will have a long course?  
 What do you fear most about your symptoms?  
 Do you think treatment is needed for this?  
 What treatment do you think might help, and with what results?

record your impressions. Always consider alternative reasons for a patient's beliefs with their relatives or advocates, and record their responses intact. If a belief is culturally unfamiliar and is coupled with functional impairment or culturally inappropriate behaviour, then it is likely to be a sign of illness.

#### First-rank symptoms

World Health Organization studies have demonstrated the existence of core symptoms of schizophrenia across cultures, although there is still debate in some anthropological quarters about the validity of such studies. There is considerable concern that first-rank symptoms can occur in other psychiatric states and in the course of culturally sanctioned methods of resolving distress (e.g. passivity, possession, exorcism, delusions of control; Jablensky, 1987). Anecdotal evidence also suggests that some first-rank symptoms are best picked up if a patient's first or preferred language is used for interviewing. Among Asian patients, for example, Schneiderian first-rank symptoms can and do occur in response to stress in subjects who may not have any family history or premorbid personality. As Rack (1990) described, the onset is often acute and dramatic, and clear onset with life events and rapid initial response to treatment should suggest a reactive condition. Desjarlais *et al* (1995) have suggested that outcome of schizophrenia varies across cultures because of a myriad of environmental and psychological factors.

#### Cognitive assessment

The historical and theoretical aspects of cognition and the role of thought and language are beyond the

scope of this paper (see Berry *et al*, 1992). Caroll & Casagrande (1958) have demonstrated that Navajo children, for example, are more likely to use form rather than colour as a basis for the classification of objects. Language is very important in shaping thinking as well as articulation. Berry *et al* (1992) argue that cognitive processes are likely to be universal but the local cultural meanings of cognitive competence will vary. The underlying theme is that cognitive functioning is related to ecological and cultural contexts – the task is to specify the general life requirements for the group as a whole and then to identify how these are communicated to the developing individual. The eco-cultural approach demands that work of this sort must be accomplished prior to individual assessment. Cultural definitions of intelligence vary and holistic rather than analytic approaches may be valued in some groups (Berry, 1984). The cognitive competence of an individual in a particular culture should thus be conceived of as progress towards culturally valued cognitive norms (Berry *et al*, 1992). The role of literacy, language and education along with other social and cultural factors must be remembered before embarking on cognitive assessments. The processes of categorisation, sorting, memory and problem-solving also are affected by culture (see Segall *et al*, 1990).

The standard cognitive assessment may yield very little diagnostic psychopathology if used blindly across cultures, especially with different languages. It is better to get third-party information on memory failure and intellectual decline. If schedules of cognitive assessment are available in the patient's primary language these must be employed bearing in mind the patient's level of education; once again, the help of an advocate or a team member who speaks the patient's first language can be invaluable (see Box 5).

## Conclusions

The patient's models of what the doctor does may be quite different from what you are able to offer. Some ethnic groups have a great respect for the health professions such that they may not confront, question, disagree or point out the problems they may be facing. This may manifest later as selective omission of medication, inaccurate reporting of symptoms, and consultation with other healers who may prove to be of benefit in treating the illness but some may deter the patient from attending services or, more commonly, offer

### Box 5. Good practice points

Elicit the first language, religion, self-defined ethnicity and identification with cultural groups (for each party concerned)  
 Define and redefine terms used by you and the patient to ensure shared understanding  
 Identify emotional idioms of distress and develop shared vocabulary with the patient  
 Ask for clarification of the unfamiliar  
 Assume nothing about the patient  
 Do not be judgemental about patterns of communication or domination of the clinical interview by one family member  
 Be sensitive to the effects of your actions  
 Communicate total confidentiality  
 Identify the scenario and setting where the patient may be most comfortable and relaxed (e.g. with family or alone?)  
 Be sensitive to religious and social taboos  
 Do not ask children or relatives (unless there is no option) to act as interpreter  
 Involve patient advocates early, with the patient's consent  
 Discuss findings with an independent person familiar with the culture and within the bounds of strict confidentiality

excessive reassurance or promise of miraculous cure, which will encourage patients to disengage with the statutory sector.

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## Multiple choice questions

- The following factors are useful in carrying out cross-cultural assessments:
  - careful listening
  - conflicting statements
  - identification of unusual idioms
  - interpretation of emotions
  - a lack of knowledge of taboos.
- The life events in a minority ethnic patient:
  - always have the same impact as in white majority
  - are always linked with onset of depression
  - may be elicited by close questions
  - do not include exit events
  - never influence mental state.
- The following are essential skills for a clinician:
  - careful listening
  - proper bedside manner
  - selective attention
  - confrontation all the time
  - awareness of non-verbal clues.
- When assessing psychological trauma after migration the following information is useful:
  - age of grandparents
  - motivation for migration
  - language problems
  - problems in adjusting to new culture
  - age at migration.
- Explanatory models for illnesses:
  - were described initially by Kleinman
  - must include aetiological causes perceived by the individual
  - must include a knowledge of the individual's culture
  - must include questions on symptoms
  - must include questions on prognosis.

### MCQ answers

1	2	3	4	5
a T	a F	a T	a F	a T
b F	b F	b T	b T	b T
c T	c F	c T	c T	c F
d T	d F	d F	d T	d T
e F	e F	e T	e T	e T