Impact of culture on psychiatric practice
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Introduction
Mental illnesses are prevalent in all societies; however, the approaches to them differ from one society to another. The variation among cultures is a major cause of such differences. Culture refers to the unique behavior patterns and lifestyle shared by a group of people that distinguish it from other groups. A culture is characterized by a set of views, beliefs, values, and attitudes. Culture shapes attitudes, stereotypes, perception, emotions, way of thinking, imagination, and the way of living among individuals in each population. It is reflected in aspects such as common sayings, legends, drama, art, philosophical thought, and religions. Culture shapes people’s behavior, but at the same time, it is molded by the ideas and behavior of the members of the culture. Thus, culture and people influence each other reciprocally and interact continuously [1].

Culture defines the normality of behavior; for example, what may be defined as a mild form of mental illness in one culture may be defined as normal behavior in another. There is evidence that a person’s cultural background colors every facet of illness experience, from linguistic structure and the content of delusions [2,3] to the unique meaning of expressed emotion [4,5]. This might explain culture-bound syndromes and their resemblance to other disorders and syndromes in other societies.

In psychiatric practice, three types of culture are present: the culture of the patient, the culture of the psychiatrist, and the medical culture in which the clinical work is practiced. They affect the symptoms’ definition, symptoms’ explanation, symptoms’ control, and the help-seeking behavior. In terms of the patients, in addition to individual factors – such as level of education, medical knowledge, and personal life experiences – culture will contribute to the patient’s understanding of illness, the perception and presentation of symptoms and problems, and reaction and adjustment to illness. The patient’s expectations of the physician, motivation for treatment, and compliance with treatment recommendations are also influenced by culture [6].

Also, the culture of the psychiatrist will shape the pattern of interaction and communication with the patient, for example, having cultural biases and expectations about the behavior and needs of a patient of a particular sex, race, or ethnicity. The culture of the psychiatrist explicitly or implicitly affects his or her attitude toward the patient, understanding of the patient’s problems, and approach to caring for the patient.

Finally, the medical culture includes traditions, regulations, customs, and attitudes that have developed within the medical service setting beyond medical knowledge and theory. The practice of general psychiatry is strongly embedded in the medical culture that has developed within the medical system. Most physicians and medical staff members have become accustomed to living within this invisible cultural system and may be unaware of its influence on their practice. It often takes outsiders to recognize the existence of medical cultures, which may differ among specialties (such as surgery and psychiatry) but share common aspects [6].

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Symptom explanation
Despite all the advances in psychiatry and discoveries regarding the pathology of psychiatric disorders, many people still hold their own cultural beliefs about mental illness. Black magic, genies, envy, and others are examples of such beliefs. This might explain why patients and their families might seek the help of traditional healers before or while receiving psychiatric care. However, this varies from one country to another [7].

Stigma
Although increased knowledge and improvements in clinical care are facilitating changes in peoples’ attitudes toward mental disorders, there are still broad cultural differences in these attitudes. These attitudes range from fear, negative views, to acceptance. For instance, in Arab societies, the mentally ill are cared for by their families; yet, there is a general negative view of psychiatric patients that delays seeking professional psychiatric advice. Although this stigma is decreasing at present due to increased awareness, it is still strongly prevalent in some regions.

Cultural differences in therapist–patient relationships
Interpersonal relations are closely defined and regulated by social and cultural norms. The expectations of the patients and psychiatrists from each other and the nature of the therapeutic relation vary among different societies.
In the US, the predominant form of physician–patient relationship is egalitarian; in contrast, in many Asian cultures, the relationship is modeled after an ideal hierarchical relationship. Also, in treatment, methods of psychotherapy that do not incorporate patients’ cultural codes are not likely to succeed in traditional societies [7,8].

**Language**

Languages vary markedly in their grammar and communication patterns. A single word can carry several meanings, and the tone of voice may alter the meaning completely. Moreover, the use of new terms among some social classes or groups (e.g. adolescents) may create some difficulties in initiating a therapeutic relation. Language can become a huge barrier between the therapist and the patient. When the therapist and the patient do not share the same language, they have to rely on interpreters for communication. Choosing a proper interpreter and utilizing the interpreter for communication is a clinical skill and art [9]. Also, nonverbal communication may vary from one culture to another. In psychiatric practice, it is important to grasp meanings expressed explicitly, tacitly, or in a symbolic way. Cultural idioms may invoke subtle or symbolic meanings of words. For example, if a Muslim person, whose faith forbids suicide, expresses the wish that God would ‘take back’ his life, the person may be indicating that he has suicidal thoughts, which must be taken seriously [6].

**Symptom formation and presentation**

In some communities in which emotional expression is not encouraged, a patient might present with a somatic complaint not because he/she actually has a somatic problem but simply because it is a culturally accepted method of expression [10]. This may also be due to the stigma associated with consulting a psychiatrist. This might explain why conversion reactions are common in Arab countries in comparison with Western societies.

**Clinical assessment and diagnosis**

As mentioned before, symptom formation and presentation might vary according to the patient’s cultural background. Also, the clinician, as a cultural person and a professional, has his or her own ways of perceiving and understanding the complaints that are presented by the patient. The clinician’s psychological sensitivity, cultural awareness, professional orientation, experience, and medical competence all act together to influence his or her assessment of the problems of a patient [11]. In many societies, a clinician needs to take into consideration the social impact of diagnostic labeling on the patient and the family. When examining a patient with a different cultural background, the clinician’s style of interviewing, perception of and sensitivity toward pathology, and familiarity with the disorder under examination all influence his or her interaction with the patient, which in turn influences the outcome of the clinician’s understanding of the disorder. Establishment of the diagnosis is influenced by the expertise of the clinician, the classification system used, and the purpose of making the diagnosis [12,13]. Culture-bound syndromes are also due to different cultural approaches (including the clinician’s approach) to certain presentations. Some of these syndromes may also actually be common in other countries, but have different names, and might differ in a few symptoms.

**Culture and psychiatric treatment**

In traditional communities, it is usually the family’s decision to seek psychiatric advice. Even the decision of hospital admission for patients who are insightless is made with the approval of the family members, in contrast to western/nontraditional societies, where it is governed by the mental health acts [7].

Also, the therapeutic models used are also influenced by culture. For example, Electro Convulsive Therapy is highly stigmatized in some societies, which affects patients’ (and the families’) approval of such a model of treatment. Psychotherapy is highly influenced by cultural factors. As mentioned before, language can be a huge barrier during therapy [1].

Other models of treatment, alternative therapies, are also present, such as Hegama, acupuncture, aromatherapy, and herbs.

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**Conflicts of interest**

There are no conflicts of interest.

**References**


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