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Cross cultural variations in psychiatrists' perception of mental illness: A tool for teaching culture in psychiatry

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ABSTRACT

A frequent debate in psychiatry is to what extent major psychiatric diagnoses are universal versus unique across cultures. We sought to identify cultural variations between psychiatrists' diagnostic practices of mental illness in Boston Massachusetts and Bangalore, India. We surveyed psychiatrists to identify differences in how frequently symptoms appear in major mental illness in two culturally and geographically different cities. Indian psychiatrists found somatic symptoms like pain, sleep and appetite to be significantly more important in depression and violent and aggressive behavior to be significantly more common in mania than did American psychiatrists. American psychiatrists found pessimism about the future to be more significant in depression and pressured speech and marked distractibility to be more significant in mania than among Indian psychiatrists. Both groups agreed the top four symptoms of psychosis were paranoia, lack of insight, delusions and auditory hallucinations and both groups agreed that visual hallucinations and motor peculiarities to be least significant. Despite a different set of resources, both groups noted similar barriers to mental health care access. However, American psychiatrists found substance abuse to be a significant barrier to care whereas Indian psychiatrists found embarrassing the family was a significant barrier to accessing care. Because psychiatrists see a large volume of individuals across different cultures, their collective perception of most common symptoms in psychiatric illness is a tool in finding cultural patterns.

1. Introduction

In the current global mental health movement to make mental health care more accessible and culturally competent, psychiatrists and other mental health workers are challenged to consider whether their expertise can cross cultures. This challenge is important to answer in the growing need to train mental health workers to work in foreign cultural settings. The World Health Organization (WHO) and other sources report that neuropsychiatric diseases like unipolar depressive disorders, addictions, bipolar disorder and schizophrenia make up 28% of the global burden of disease among non-communicable diseases. They are economically more disabling than cardiovascular disease or cancer (Bloom et al., 2011). While access to mental health is essential to improving economies of the world and quality of life among people, there is a dearth of resources and expertise. Addressing this need requires culturally minded psychiatrists, medical anthropologists and epidemiologists to weigh-in on the complexity, presentation and course of mental illness (Becker and Kleinman, 2013).

Medical expertise is needed to build global innovations in diagnosis, therapeutics and access. But how does this expertise cross cultures? When constructing curricula for global psychiatry to train future doctors, should we also consider whether all psychiatrists see mental illness the same way despite using similar criteria? Are psychiatrists diagnosing the same disorder but considering different symptom clusters to get to their diagnosis? And if so, how can we harness this information in order to better identify and treat mental illness in different parts of the world? To address this inquiry, we sought to identify cultural variations between psychiatrists' perceptions of most common presentations of mental illness in Harvard affiliated hospitals in the Longwood area of Boston, MA and a comparable large mental health center in Bangalore, India. This sampling survey study compared psychiatrists' perceptions of the most common symptoms of major mental illness in two separate cultural environments.

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2. Methods

This study was approved under exempt status by the institutional review board at the Beth Israel Deaconess Medical Center in Boston, MA. In December of 2013, an anonymous survey was sent out to fourth year residents and psychiatrists practicing in various departments in the Boston area, Beth Israel Deaconess Medical Center (BIDMC), Brigham and Women's Hospital (BWH) and Massachusetts Mental Health Center (MMHC) through a web-based online Survey Monkey program. In January 2014, the same survey was circulated in document form through email to psychiatrists in Bangalore, India at the National Institute of Mental Health and Neuroscience (NIMHANS). We used this method, as this cohort was less familiar with the survey monkey program.

2.1. Participants

The following people met the study criteria: licensed psychiatrists that were currently training in psychiatry or practicing in psychiatry and were working in an academic institution in Boston, USA or Bangalore, India. In Boston, psychiatrists were contacted using all listservs that exclusively contained practicing psychiatrists at each of the medical centers. They were sent a link to the survey through the email. In Bangalore, email listservs were used to send out a word document version of the study that was later handed back in an envelope. Survey takers remained anonymous and the only demographic data contained within the survey was age, years of training and type of practice. Those who answered the survey questions according to the instructions that were written on the survey were included in the study. Those who did follow instructions, which asked to number symptoms from most commonly seen to least commonly seen, were those who used the same ranking number multiple times on different symptoms. Two survey participants were excluded for ranking almost all of the symptoms equally. At final count, 101 psychiatrists took the survey. There were 99 academic psychiatrists that were included in the study, 47 in Boston and 52 in Bangalore. The survey asked each person to rank 9–10 symptoms from most commonly seen to least commonly seen in three types of acute major mental illness: major depression, mania, and psychosis. The symptoms were gathered from both ICD-10 and DSM-IV-TR and the survey included each manifestation of a symptom from both manuals of diagnostic criterion. The psychiatrists were also asked to rate barriers to mental health care access from most frequently seen to least frequently seen from a compiled list of care access issues.

2.2. Data collection and analysis

All of the data from the surveys were reorganized on Microsoft Excel (Redmond, Washington) and then transferred and analyzed on Statistica (Version 10). We compared measures of central tendency without assuming normality between the two groups. We had two groups of ordinal data that were not parametrically distributed, so we used the Mann-Whitney *U* test to determine results. The data below have a U value, Z value and p value to determine significance.

3. Results

3.1. Study sample

This study resulted in 99 responses out of 101 responses; two were excluded due to not filling out the survey correctly. Both exclusions occurred in the Indian clinician group as they had paper surveys and were able to use the same ranking number multiple times whereas the electronic survey did not allow for this issue. We queried the psychiatrists' age and years in practice. There was no statistical significance in age or years of psychiatric practice between the US group and the India groups of clinicians. The mean age in the US was 44.425 and the mean age in India was 40.867 ($p = 0.3583$). The mean years of practice in the US were 15.90 and in India were 15.50 ($p = 0.3994$). Because in the United States, medical doctors do an extra 4 years of college whereas in India, students enter 6 years of medical school directly after high school, this may account partly for the slightly older age for the American psychiatrists.

3.2. Depression symptoms

Indian psychiatrists perceived somatic symptoms like somatic pain to be significantly more common in depression ($U = 304$, $p < 0.00$) than American psychiatrists. Other physical neurovegetative symptoms like insomnia ($U = 689.6$, $p < 0.00001$) and diminished appetite ($U = 361.500$, $p < 0.00001$) were also more significantly frequent in the Indian psychiatrists' view whereas psychological markers like pessimism ($U = 635.5$, $p < 0.00001$) were significantly more frequent in the diagnosis of depression among American psychiatrists. Factors such as being easily fatigued, thoughts of self-harm, suicidal thoughts, and difficulty with attention and concentration showed no statistical difference and ranked similarly in frequency between the two clinician groups. Though both groups felt that decreased interest in pleasurable activities was the most common symptom seen in depression, American psychiatrists showed a trend to report it as being more commonly seen than did Indian psychiatrists ($U = 972.500$, $p = 0.0598$) Graph 1.

Indian psychiatrists perceived violent aggressive behavior ($U = 558.0$, $p < 0.00001$) and anger ($U = 417.000$, $p < 0.00001$) to be significantly more common in manic patients than did American psychiatrists. American psychiatrists more frequently found pressured speech ($U = 772.5$, $p = 0.001102$) among patients with mania. Both groups found decreased need for sleep and pressured speech to be among their top two symptoms used to diagnose mania in patients but disagreed about symptoms of anger and agitation. Both groups agreed that they were least likely to see the symptoms of hypersexuality and tearfulness in their manic patients, which is often used to diagnose mixed state mania Graph 2.

Both American and Indian psychiatrists reported the most frequent symptoms of psychosis to be paranoia, lack of insight, delusions and auditory hallucinations and both groups agreed that visual hallucinations and motor peculiarities to be least common symptoms seen in psychotic disorders. Certain symptoms were ranked significantly differently between the two groups of psychiatrists. American psychiatrists saw breaks in train of thought (($U = 509.0$, $p < 0.00001$) significantly more commonly and Indian psychiatrists saw lack of interest in hygiene ($U = 565.000$, $p = 0.000008$), lack of interest in social activities or work ($U = 607.500$, $p < 0.00001$) and peculiarities in voluntary movement ($U = 477.500$, $p < 0.00001$) significantly more commonly than American psychiatrists Graph 3.

Both groups reported barriers to mental health care access similarly. Both agreed that difficulty acknowledging the problem and lack of supports (social and financial) were the biggest obstacles in getting mental health care. However, among these variables, some seemed more noticeably frequent to one group than the other. American psychiatrists found substance abuse ($U = 780.500$, $p = 0.001337$) and homelessness ($U = 860.500$, $p = 0.007920$) to be a significant barrier to care compared to Indian psychiatrists. Indian psychiatrists found embarrassing the family ($U = 493.500$, $p < 0.00001$) and having no mental health services in the area ($U = 488.000$, $p < 0.00001$ a more significant