ORIGINAL COMMUNICATIONS

PSYCHOSOCIAL/CULTURAL ISSUES IN MEDICINE AND PSYCHIATRY: TREATING AFRICAN AMERICANS

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In general, we are raised in a specific cultural environment, and consequently, we have a common sense of identity, shared standards, and religion. The effects of this commonality carries over into health-care situations, including health maintenance and disease prevention. This article provides an overview of how psychosocial/cultural issues have been used with insensitivity to race, culture, and the value orientations of African Americans. It is concluded that the training of all health-care practitioners should include psychosocial/cultural aspects of illnesses. (*J Natl Med Assoc.* 1995;87:857-860.)

Key words • psychosocial issues • cultural issues • psychiatry • African Americans

Culture, race, and ethnicity influence clinical relationships, treatment compliance, and ultimately, the recovery from diseases. This article provides an overview of psychosocial and cultural issues as related to African Americans, and how sensitivity to race and culture can dramatically improve patient care.[1,2] In general, we are raised in a specific cultural environment, and thus, we have a common sense of identity, shared standards, and religion. The effects of this commonality carries over into health-care situations, including health maintenance and disease prevention.

In treating someone from a different race/culture, two types of professional attitudes or anxieties generally are observed. Conceptually, there are esthetic anxiety and existential anxiety.[3] Aesthetic anxiety refers to the fears engendered in the provider by patients whose physical appearance deviates markedly from what is considered appealing. Existential anxiety refers to the threat of becoming like our patients. This anxiety is manifested in the thought "but for the grace of God, there go I."

It is my clinical observation that African Americans have a keen sensitivity that enables one to detect when race and culture are under attack. Similar sensitivity led Franz Fanon, an Algerian psychiatrist, to develop several novel approaches to the cultural dimensions of medicine. Fanon noted during the French-Algerian War that while European patients responded favorably to medical care offered them in a highly respected French hospital, the Muslim natives, including those with minor wounds, gradually sunk into deep depressions and ultimately refused treatment. Fanon concluded that the hospital's egalitarian approach to medicine was inappropriate for the Muslims, and the staff did not take into consideration their Muslim patients' culture and life experiences. For example, the Muslim patients did not frequent the cafes set up for patients where women were allowed. Such male-female intermingling is inconsistent with traditional Muslim culture. After separate facilities were established for men and women, the Muslim patients not only visited cafes designed for men, but treatment responses improved.[4]

SPECIFIC PSYCHOSOCIAL/CULTURAL ISSUES

Several years ago, anthropologists began reporting specific medical/psychiatric conditions observed among various racial minority groups that defied the diagnostic classifications of Western-trained clinicians. Anthro-

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pologists observed that when Western-trained psychiatrists encountered syndromes of mental disorders among non-Western societies that did not fit easily into psychiatric diagnostic classifications, the syndromes were conveniently classified as "cultural-bound," ie, Amok, Koro, Piblokto, and Whitago, etc.[5] The fact that these conditions are observed frequently makes no difference; they simply are not admitted into the mainstream diagnostic classification of psychiatric disorders.

Gaines,[6] an anthropologist, states that psychiatric illnesses in Western culture are viewed as "authentic," and similar mental disorders observed in non-Western cultures are viewed as "contaminated" or distorted by culture. In medicine, as in psychiatry, when a clinical diagnosis is not readily apparent in a member of a different racial group from the health-care provider, the patient is at risk of being labeled hysterical. Equally as important as diagnosis is the difficulty health-care providers encounter in evaluating and treating diseases in patients who are psychosocially and culturally different.

Despite apparent difficulties with diagnosing and treating patients who are "different," little progress has been made toward including psychosocial/cultural issues into the curriculum of health-care disciplines. Mere contact alone between people of different races and cultures may not automatically produce favorable attitudes.[7] In the early phases of health-care training, an in-depth knowledge about psychosocial issues and different cultural values is recommended to better understand the patients' and providers' attitudes, especially in terms of symbolic racism. Symbolic racism is the abstract ideological thinking that racial minorities are violating moral values of health-care providers and are making unreasonable demands on the medical system and society, eg, repeated out-of-wedlock births and demanding nonessential medical services that bankrupt health-care systems.[8]

BELIEF SYSTEMS OF SOME AFRICAN AMERICANS

It is noted that some African Americans believe there are natural diseases that plague humankind and that some diseases occur as a consequence of evil influences or spirits. Snow,[9] in his writings about black folk medicine, stated that it is a common belief the world over that events in our lives can be controlled by magical practices. Moreover, I am inclined to agree that many of our "medical truths" of today may become tomorrow's quackery.

The National Cancer Institute is calling for 18 000 men, 55 and older, to take part in a 7-year test of a drug that successfully may treat prostate cancer (*The News and Observer Newspaper*. October 14, 1993:5A). Half of the volunteers will be given the drug finasteride (Proscar, West Point, Pennsylvania). The other half will be given a placebo, referred to in African-American communities as a "sugar pill." The incidence of cancer will be compared at the end of the trial between the two groups. Although the participation of African-American men is welcomed, it is unlikely that African-American men will eagerly participate, especially since it was reported that a small number of men on finasteride complained of impotence, reduced sexual desire, and decreased volumes of ejaculation. The fact that the medical profession will independently assign the placebos undoubtedly is sufficient enough to raise cultural suspiciousness.

USE OF FOLK MEDICINE

To achieve compliance with medical treatment, cultural sensitivity is a prerequisite. Ostensibly, some health-care practitioners are unaware that African Americans may continue to use prescribed and folk/patent medicine simultaneously, eg, some apply vinegar to their forehead and eat garlic to control hypertension, while continuing to take prescribed medications. In fact, many African Americans believe there are superior medicinal properties to a variety of herbs, turpentine, and lotions. Suffice it to say, they believe that compliance with biomedical treatment does not require discontinuing home remedies even though the combination of these remedies may be counteractive. From personal experience, I believe that health-care professionals can reduce this behavior when there is open discussions about why medicines are being prescribed, and the benefits and risks of the medicines are explained.

PITFALLS IN CARING FOR AFRICAN AMERICANS

Friedman,[10] a sociologist, states that direct contact is important for the following reasons: 1) the provider must assess the special quality and intensity of the patient's symptoms, emotions, and pains, and 2) the provider must create positive expectations, provide emotional support, and elicit the patient's compliance with treatment. Since ancient times, physicians and other healers have relied on careful observations to diagnose illnesses and to assess the patient's subtle cues.

Sociocultural issues with African Americans include:

- eye contact,
- royal touch,
- facial expressions, and
- language and symbolism.

Eye Contact

I doubt seriously today that many health-care providers are familiar with the documented patterns of eye contact in African Americans. For example, it has been observed by human behavioral scientists that a significant number of African Americans use eye contact in patterns that differ from white Americans. White Americans usually tend to maintain eye contact when listening and look away while speaking whereas African Americans seem prone to look away while listening and maintain eye contact while speaking.[11] Attention to different eye movements of African Americans may help to diminish the feelings of alienation between provider and patient.

Royal Touch

Noted among African Americans is the persistent belief in the curative powers of the "royal touch," even though there is no scientific validation of such cures. Touch obviously attests to the tremendous symbolic value of physical contact in healing. Some African Americans report that they feel better after having received a physical examination in which the health professional touches them to "examine" rather than merely ask questions. The desire to be touched by authority figures is not confined to health-care practitioners—it also extends to high status political figures, athletes, and religious authorities. This suggests that touch has retained its symbolic value as a kind of "blessing" involving the transfer of power. African-American faith healers have long used the technique of "laying on of hands," and its efficacy is from the transfer of a healing spirit. Many Western-trained health-care professionals consider touching as quackery, but since Harlow's classic studies of the physical and emotional health of monkeys raised with wire versus cloth surrogate mothers, the importance of touch to health development has been widely accepted.[12]

Not only do African Americans have strong feelings about where, when, and how to be touched, but it is equally as taboo for East Asians to be touched on the head.[13] It would facilitate matters if the examiner would first inform the East Asian patient that an ear is about to be examined prior to placing a hand on the patient's head and grasping an ear lobe. Some negative feelings about being touched are noted when African-American men resist the digital rectal examination, believing this to be taboo and repulsive. The cultural resistance to rectal manipulation is no doubt intertwined psychologically with issues of masculinity and sexual perversion.

Facial Expressions

Facial expressions are controlled by most professionals, but African Americans, victims of racism, can quickly recognize distinct emotional states from facial expression. Early in life, many African-American children are taught to observe the facial expressions of their parents to validate approval or disapproval. The use of facial expression is not unique to African Americans because centuries ago, tribal medicine men wore elaborate masks during healing, which undoubtedly carried significant psychological powers. The work of Ben-Sira confirms that patient treatment is heavily influenced by the provider's facial expression.[14]

Language and Symbolism

The evasiveness of African Americans during history-taking continues to be extremely baffling to some professionals. Hence, African Americans may be incorrectly labeled as obstreperous or "paranoid." To begin with, African Americans should never be diagnosed as paranoid until "healthy" suspiciousness has been considered, a utilitarian way of coping in a biased environment. There is sometimes a delay in answering questions, and the answers given may be deliberately designed to be misleading, which is a defensive mechanism. Answers may be brief or expansive, but serve the purpose of protecting the patient from a perceived "outsider."

Western-trained professionals must learn a new meaning of words when treating racial minorities. While it is true that African Americans speak English, the same terms used to describe a disease or symptoms may be applied differently to convey a thought. Historically, the language of African Americans is complicated by the fact that words were used by slave ancestors to simultaneously express and conceal feelings. The oral traditions of African Americans are particularly prominent in today's "rap" music, folk tales, blues, and spirituals, describing the African-American experience. It is generally accepted that there are specific conceptual language differences among various racial-ethnic groups.

It also has been observed that there are common beliefs about physical states across cultural lines. For example, blood may be spoken of as too much, too little, too thin, dirty, high blood, or low blood. Another common cultural phenomena is the concept of "draft" as the cause for colds and arthritis. A draft is an air current that one should avoid while sweating. It is believed by several different cultures that the body is especially susceptible to a cold when the skin "pores are open."[15]

Western-trained professionals may mistakenly con-

sider "heart trouble" to be potentially life threatening, but an understanding of the symbolism of heart trouble in African-American culture can prevent needless and costly cardiac evaluations. For the African American in the Pentecostal Holiness Church, heart trouble may refer to "spiritual heart trouble," a condition in which Satan or demons entered into the individual's life. Spiritual heart trouble or simply heart trouble, as it is referred to by some Pentecostal Holiness members, affects twice as many women as men. The symptoms usually noted are tachycardia, uncontrollable drowsiness, interrupted sleep, headaches, weakness, dizziness, and the loss of "spiritual joy."[16,17]

CONCLUSION

The objective of this article is not to denigrate orthodox Western medicine or psychiatry, but to critically examine how we have failed to use psychosocial/cultural issues advantageously with African Americans. Albert Schweitzer once said, "It is our duty to remember at all times and anew that medicine is not only a science, but also the art of letting our own individuality interact with the individuality of our patients."[18] Regrettably, we do not seem sufficiently interested in the psychosocial/cultural experiences of our patients and how their life experiences are shaped and distorted, as the case may be, by social institutions and by the grinding, crushing wheels of our capitalist and racist society.

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