Somatization among ethnic minorities and immigrants: why does it matter to Consultation Liaison Psychiatry?

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Introduction

A key issue in research in the area of mental health of migrants/ethnic minorities is to understand the interplay of ethnicity, migration and cultural background with somatization. While it is difficult to study somatization in general, it is even more challenging among migrants or persons from different cultural backgrounds, due to methodological limitations and obstacles. This is nonetheless the great strength of the field, as Engel himself originally noticed, while establishing a link between Consultation Liaison Psychiatry (CLP) and cross-cultural psychiatry (1).

A large WHO study of the mid 90s analysed the incidence and prevalence of somatization in 15 centres in four continents (2). The results showed 1) a high variability in the occurrence of

somatoform disorders across the different sites; that 2) “neither differences nor similarities in the rates of occurrence of somatization nor their correlates are easily explainable on the basis of cultural or developmental differences alone”; and that 3) differences appeared to be closely related to the doctor-patient relationship and organization of care (3). Somatization is ubiquitous, and presents universally across very different cultural backgrounds.

Migration, on the other hand, does contribute to the incidence of somatization, suggesting that the study of somatization among migrants may support our understanding of somatization itself. Globalization and migratory phenomena are increasingly considered to have brought back illnesses or disorders that were rarely seen in Europe and North America (4), not only tuberculosis and tropical infectious diseases, but also relational and behavioural styles that may be described as the former conversion and dissociative disorders, or “hysteria”. A question remains, however, as to the veracity of this impression.

The clinical questions

The central clinical question is whether migrants and/or persons from specific cultural backgrounds are more susceptible to somatization. Available research in this area is inconclusive and methodologically problematic (5, 6).

A further question concerns the notion of cultural distinction in our era of globalization. Chaturvedi & Buhgra (7) stated that “because of globalization and urbanization, idioms of distress and explanatory models of Common Mental Disorders (CMD) will change from culturally influenced to perhaps more universally accepted explanations”. But, as we wait for this possibly inexorable process, we have to refer to the analysis by Laurence Kirmayer of the cultural meaning of somatization (8): “psychological theories of somatization focused on individual characteristics must be expanded to recognize the fundamental social meanings of bodily distress”. In cultures where “the harmony of the family and group is more important than individual anatomy”, somatization might be a refined superior way to “have one’s cake and eat it too”, a legitimate and codified pattern of expressing suffering. This anthropological perspective may contribute to the understanding of somatization: a recent study (9) found that somatic idioms of distress was the main psychopathological dimension underlying psychotic disorders in a sample of migrants attending the transcultural psychiatric service in Bologna, Italy.

The incidence of somatization among people of different ethnic or cultural background is one of the leading reasons for under-recognition and under-treatment of mental disorders among immigrants at primary and secondary level of care. Some primary care studies showed that CMD are less recognized and treated in ethnic minorities than in native born populations, even when rates of consultations are higher among migrants (6, 10-12). Poor levels of detection and treatment of CMD among migrants in primary care have been related to difficulty in recognizing somatically presented CMD (13-16). Moreover, GPs show lower rates of referral of CMD patients to Mental Health Services (17, 18), and of drug therapy initiation on members of certain ethnic minority groups (19-21), especially when mental disorders are presented somatically. Migrants tend to under-utilize mental health services and to over-utilize emergency services (22, 23). Developing cultural competent CLP interventions aimed at overcoming barriers to effective mental health treatment for migrants and ethnic minorities is therefore a key issue of public health.

Since 2007, a group of clinicians and researchers within the scientific network of the EAPM (former EACLPP) started sharing their common interest and curiosity about the subject of mental health of migrants, under the specific perspective of somatic expression of psychic distress. Common ideas and experiences as well as specificities and differences deriving from different socio-cultural contexts and organizations of health care provision were discussed, also by means of scientific symposia offered during the EACLPP meetings. The group progressively acquired a more stable structure culminating in the formal institution of the Cultural CLP Special Interest Group (SIG), in 2010. Ilaria Tarricone from the University of Bologna, Italy and Ronald Burian from the KEH in Berlin, Germany, co-lead the SIG. Various members of the SIG have been involved in research projects addressing different sub-items and presentations of mental health of migrants (24-31). These previous experiences were relevant as they suggested what the best further objectives for the SIG should be.

Conclusions and implication for CLP

The Cultural CLP SIG currently constitutes a forum within the EAPM where to exchange clinical and research experiences with migrants and ethnic minorities. The main aim of the SIG is to promote and disseminate the translation of research findings and excellent clinical experience into standard of care, by the way of three main actions: 1) discussion of cultural issues of interest in establishing mental health services for migrant patients in different European countries; 2) advice on training

in cultural competence; 3) promotion, organization, development of research on cultural effectiveness of care and care of mental health needs of migrants.

A multi-disciplinary and international approach, as allowed within the EAPM SIG, may promote cross-cultural effectiveness in detecting and managing symptoms of somatization among migrants. As a SIG, we often experience the difficulty of putting together our heterogeneous backgrounds, but also enjoy and value this opportunity.

The EAPM SIG on Cultural CLP welcomes colleagues interested in this field of research and clinical practice, who share our common perspective that a bio-psycho-social-cultural approach to mental disorders is pivotal in the understanding of their complexity.

References

1. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977;196(4286):129-36.
2. Gureje O, Simon GE, Ustun TB, Goldberg DP. Somatization in cross-cultural perspective: a World Health Organization study in primary care. Am J Psychiatry. 1997;154(7):989-95.
3. Gureje O. What can we learn from a cross-national study of somatic distress? J Psychosom Res. 2004;56(4):409-12.
4. Rechel B, Mladovsky P, Ingleby D, Mackenbach JP, McKee M. Migration and health in an increasingly diverse Europe. Lancet. 2013;381(9873):1235-45.
5. Fritzsche K, Anselm K, Fritz M, Wirsching M, Xudong Z, Schaefert R. Illness attribution of patients with medically unexplained physical symptoms in China. Transcult Psychiatry. 2013;50(1):68-91.
6. Tarricone I, Stivanello E, Poggi F, Castorini V, Marseglia MV, Fantini MP, et al. Ethnic variation in the prevalence of depression and anxiety in primary care: a systematic review and meta-analysis. Psychiatry Res. 2012;195(3):91-106.
7. Chaturvedi SK, Bhugra D. The concept of neurosis in a cross-cultural perspective. Curr Opin Psychiatry. 2007;20(1):47-51.
8. Kirmayer LJ, Young A. Culture and somatization: clinical, epidemiological, and ethnographic perspectives. Psychosom Med. 1998;60(4):420-30.
9. Braca M, Berardi D, Mencacci E, Murri MB, Mimmi S, Allegri F, et al. Understanding psychopathology in migrants: A mixed categorical-dimensional approach. Int J Soc Psychiatry. 2013.
10. Commander MJ, Dharan SP, Odell SM, Surtees PG. Access to mental health care in an inner-city health district. II: Association with demographic factors. Br J Psychiatry. 1997;170:317-20.
11. Borowsky SJ, Rubenstein LV, Meredith LS, Camp P, Jackson-Triche M, Wells KB. Who is at risk of nondetection of mental health problems in primary care? J Gen Intern Med. 2000;15(6):381-8.
12. Husain N, Waheed W, Tomenson B, Creed F. The validation of personal health questionnaire amongst people of Pakistani family origin living in the United Kingdom. J Affect Disord. 2007;97(1-3):261-4.
13. Wilson M, MacCarthy B. GP consultation as a factor in the low rate of mental health service use by Asians. Psychol Med. 1994;24(1):113-9.
14. Williams R, Hunt K. Psychological distress among British South Asians: the contribution of stressful situations and subcultural differences in the West of Scotland Twenty-07 Study. Psychol Med. 1997;27(5):1173-81.
15. Bäärnhielm S, Ekblad S. Turkish migrant women encountering health care in Stockholm: a qualitative study of somatization and illness meaning. Cult Med Psychiatry. 2000;24(4):431-52.

16. Aragona M, Tarsitani L, Colosimo F, Martinelli B, Raad H, Maisano B, et al. Somatization in primary care: a comparative survey of immigrants from various ethnic groups in Rome, Italy. Int J Psychiatry Med. 2005;35(3):241-8.
17. Gillam SJ, Jarman B, White P, Law R. Ethnic differences in consultation rates in urban general practice. BMJ. 1989;299(6705):953-7.
18. Bhui K, Bhugra D, Goldberg D, Sauer J, Tylee A. Assessing the prevalence of depression in Punjabi and English primary care attenders: the role of culture, physical illness and somatic symptoms. Transcult Psychiatry. 2004;41(3):307-22.
19. Cornwell J, Hull S. Do GPs prescribe antidepressants differently for South Asian patients? Fam Pract. 1998;15 Suppl 1:S16-8.
20. Melfi CA, Croghan TW, Hanna MP, Robinson RL. Racial variation in antidepressant treatment in a Medicaid population. J Clin Psychiatry. 2000;61(1):16-21.
21. Hull SA, Cornwell J, Harvey C, Eldridge S, Bare PO. Prescribing rates for psychotropic medication amongst east London general practices: low rates where Asian populations are greatest. Fam Pract. 2001;18(2):167-73.
22. Padgett DK, Patrick C, Burns BJ, Schlesinger HJ. Ethnicity and the use of outpatient mental health services in a national insured population. Am J Public Health. 1994;84(2):222-6.
23. Zhang M, Booth BM, Smith GR. Services utilization before and after the prospective payment system by patients with somatization disorder. J Behav Health Serv Res. 1998;25(1):76-82.
24. Tarricone I, Atti AR, Salvatori F, Braca M, Ferrari S, Malmusi D, et al. Psychotic symptoms and general health in a socially disadvantaged migrant community in Bologna. Int J Soc Psychiatry. 2009;55(3):203-13.
25. Tarricone I, Stivanello E, Ferrari S, Colombini N, Bolla E, Braca M, et al. Migrant pathways to community mental health centres in Italy. Int J Soc Psychiatry. 2011.
26. Tarricone I, Atti AR, Braca M, Pompei G, Morri M, Poggi F, et al. Migrants referring to the Bologna Transcultural Psychiatric Team: reasons for drop-out. Int J Soc Psychiatry. 2011;57(6):627-30.
27. Husain N, Creed F, Tomenson B. Adverse social circumstances and depression in people of Pakistani origin in the UK. Br J Psychiatry. 1997;171:434-8.
28. Creed F, Winterbottom M, Tomenson B, Britt R, Anand IS, Wander GS, et al. Preliminary study of non-psychotic disorders in people from the Indian subcontinent living in the UK and India. Acta Psychiatr Scand. 1999;99(4):257-60.
29. Duddu V, Husain N, Dickens C. Medically unexplained presentations and quality of life: a study of a predominantly South Asian primary care population in England. J Psychosom Res. 2008;65(4):311-7.
30. Gater R, Tomenson B, Percival C, Chaudhry N, Waheed W, Dunn G, et al. Persistent depressive disorders and social stress in people of Pakistani origin and white Europeans in UK. Soc Psychiatry Psychiatr Epidemiol. 2009;44(3):198-207.
31. Ta TM, Neuhaus AH, Burian R, Schomerus G, von Poser A, Diefenbacher A, et al. Mental Health Care Utilization of First Generation Vietnamese Migrants in Germany. Psychiatr Prax. 2014.