Multicultural Issues in Adolescent Health Care

> ***Culture denotes a system of inherited concepts expressed in symbolic forms and transmitted through a pattern of meanings by which people communicate, perpetuate and develop their knowledge about and attitudes toward life.***
> ***(Geertz 1988)***

This very important subject was the stimulus for a whole day joint IAAH/SAM workshop in Vancouver. Contributions were many and varied - an interesting collection of comparisons of health measures, disease concepts and service provision in varying cultures; but perhaps leaving one ultimately more than a little perplexed as to 'where do we go from here?'This is a subject that I had pondered over for some years - from the personal viewpoint I knew how it felt to be 'between' worlds in cultural terms - brought up in England but with Italian family. Some of my experiences are echoed in the contributions below. I have also attempted at intervals to raise the issue of culture with staff and residents in our unit (see workshop results below). Nevertheless making concrete and useful changes rather than debate issues is difficult.

One inherent difficulty lies in the fact that cultures change - there tends to be a drift towards others norms - particularly in the adolescent sphere where life moves fast, boundaries are shifted and 'cultures' are exposed to American films and media heroes. Many of the 'cultures' which I have studied have been subject to this movement - in Italy youth were previously much more repressed and controlled than in England, much to my consternation as a teenager - now drug taking, abortion, divorce etc. are part of the scene and Italian teenagers are if anything freer than UK peers. Russian youth were until recently shining examples of polite school pupils who stood up when the teacher entered the room. The groups I brought over to England suffered 'culture shock' in London schools. Now Moscow youth have a very high rate of truancy, teen pregnancy, drug abuse, drinking and prostitution. Something unimaginable ten years ago. The comparative work I have attempted between Jamaican youth in the Caribbean and those who live in UK changes with great fluidity - looking for similarities is more rewarding than looking for differences.This concept of cultural drift is echoed by Bob Blum in his article **"Global trends in adolescent health"** (Blum RW. JAMA. 265(20):2711-9) .... *Increasingly, morbidity and mortality trends for young people in developing nations are paralleling those in the industrialised world. As infectious causes of mortality diminish, unintentional injuries, suicide, homicide, war, and maternal mortality represent the primary causes of death in the second decade of life for most nations where data are maintained. As developing nations increasingly place priority on the education of their youth, early marriage and precocious child rearing are discouraged, and other problems, such as out-of-wedlock childbirth and illicit*

abortions, emerge. Problems such as substance abuse and suicide arise with the urban migration, increased unemployment, and disruption of traditional social structures that are experienced as developing countries industrialise.

Unfortunately it often seems that cultures learn the 'negatives' from each other before or instead of the 'positives'. In my travels I have attempted to learn what the positive, coping strategies are for a given culture which could be extrapolated for 'use' elsewhere - but have generally been frustrated in this task as such norms 'do not travel well'. With regard to youth of Jamaican origin - in our last journal Dr Aggerey Burke (one of our few Jamaican psychiatrists working in London) made the point that emotional disturbance and the diagnosis of psychiatric illness among black youth is much higher in England than in Jamaica. The level of arousal seen in London is much higher than in Afro/Caribbean countries - he described the most commonly seen syndrome as '*..Sadness, fear, hatred, anger constituting confused emotions - emotions that cannot be balanced; and in it's extreme form it is fury. Extreme and confused emotions are mixed with extreme and confused thoughts in the most extreme and confused persons.*' This situation we discussed, was partly brought about and confounded by the fact that half the children going into care are black and in boroughs with a 20% black population 62% of young offenders are black and 65% of school exclusions. This perpetuating legacy of the care system is something which is not seen in Jamaica where very few children ever go into care. Why can't we in England learn from and use the Jamaican system of intervention?
Dr Frederick Hickling, a psychiatrist in Kingston, Jamaica views the emerging Jamaican system of community care for the mentally ill as a great improvement on the 'colonial style' mental hospital and the idea of institutionalisation. Generally this underlines the difference in philosophy - greater community acceptance of emotional illness and diverse lifestyles, coupled with greater reliance on community or extended family support in personal or family breakdown. Dr Hickling's centre in Kingston has many similarities to Youth Support House - using a multidisciplinary approach and utilising drama, music and media - however there is still something inherently Jamaican in his set up and something inherently British in ours which is hard to define. Basically we do not have the extended family network to rely upon for support of our patients and have to 'create' an artificial support system. Is this support system breaking down because of increased reliance on 'capitalist' values - i.e. an acquisitive industrial society?

This view is argued in the article "**Psychiatric morbidity in developing countries and American psychiatry's role in international health**". (Sugar JA. Kleinman A. Eisenberg L. Hospital & Community Psychiatry. 43(4):355-60, 1992) "....
Economic and social change in the developing countries of Asia, Africa, Latin America, and the Pacific Islands is associated with increased rates of behaviour-related illnesses, including psychiatric disorders, alcoholism, and substance abuse. Between 10 and 20 percent of the presenting problems in primary

care settings in those countries are psychosocial. The authors provide an overview of the epidemiology of psychiatric and psychosocial morbidity in developing countries and summarise its effect on medical care systems in those settings. They suggest that American psychiatry increase its involvement in improving mental health care in developing countries.

Consultation should be directed toward priorities determined locally in those countries, including assessment of current clinical practices, applied epidemiological research, and training of indigenous researchers."

Support systems vary depending on the type of extended family and the role of the family in society. Japanese family structures are based on different value systems from those prevailing in British families as evidenced in **"Connectedness versus separateness: applicability of family therapy to Japanese families"** (Tamura T. Lau A. Faculty of Education, Tokyo Gakugei University, Japan. Family Process. 31(4):319-40) This article, a product of the two authors' multicultural experiences, contrasts British and Japanese families in order to examine the applicability of the Western model of family therapy to Japanese families. Areas where the Western model is incompatible are identified, and modifications to fit the Japanese indigenous model are suggested.

" .... *The most significant difference in value systems between the two cultures is the Japanese preference for connectedness. The Japanese person is seen as a part of the embedded interconnectedness of relationships, whereas British norms prioritise separateness and clear boundaries in relationships, individuality, and autonomy. This value orientation is manifested in the Japanese language, hierarchical nature of the family structure, the family life cycle, and the implicit communication style.*

Systemic thinking, which deals with the pattern of relationships, is valid for all families regardless of cultural differences. But therapists should note that the preferred direction of change for Japanese families in therapy, is toward a process of integration--how a person can be effectively integrated into the given system--rather than a process of differentiation. An authoritative therapist style, the use of individual sessions, silence, and other non-verbal techniques are relevant to bringing about the desired change toward better integration of the individual with his or her networks."

Bob Blum presented an overall view of culture health and illness in adolescence which to an extent brought together some of the themes expressed in the workshop. He drew attention to the recommendations of the Wingspread conference on Culture and Chronic Illness - to

- Include persons from diverse cultural and ethnic groups in all aspects of research, training, service delivery and policy formation
- More understanding needs to be developed of distinct cultural groups and variations within ethnic groups rather than focusing on aggregated racial groups
- More attention should be given to the way language is used in communicating with persons from diverse cultural groups.