

Idiom of Distress or Delusional State? Cultural Clash as the Cause of Misdiagnosis: A Case Report

Anne-Marie Ulman, MD, and Faina Bar, MD

Beer Yaakov Mental Health Center and Sackler School of Medicine, Tel Aviv University, Ramat Aviv, Israel

ABSTRACT

The “Beta Israel” (House of Israel) represent a total number of more than 100,000 individuals. Ethiopian-Jewish culture is based on a tribal cultural model. With their arrival in Israel, many difficulties surfaced. Ethiopian Jews had to deal with cultural choices that challenged their traditions. It has been suggested that the trauma of their journey coupled to the difficulties of the adaptation process to Israeli society, “the culture shock,” was directly responsible for psychopathology found among this population. It also appeared that culture plays a central role in the construction of the clinical picture, blurring at times the boundary between expressions of distress and pathology. It became increasingly difficult to draw the line between culturally normative behavior and psychopathology. The following case report underlines the importance of socio-cultural considerations in both staff and patients, and illustrates the dangers of misdiagnosis due to patient-therapeutic team cultural clash. A 41-year-old woman of Ethiopian origin was hospitalized for suspected schizophrenia. Because of the striking contrast between the patient’s behavior, responses and so-called “psychotic content,” possible misunderstanding based on cultural differences was considered by the clinical management team. This case underlines the dangers of the psychiatric diagnostic process, emphasizes the important role of socio-cultural backgrounds of both staff and patients in patient management and encourages the consideration of cultural factors in all patient evaluations.

Beginning in 1977, and followed by the much publicized airlift in 1984 and 1991, a process of emigration brought the Ethiopian Jewish community to Israel. Today the “Beta Israel” (House of Israel) represent a total number of more than 100,000 individuals (1). Ethiopian Jews preserved their cultural integrity, living in isolated communities spread throughout hundreds of villages in the northwestern rural areas of the country, especially in the Gondar and Tegray regions. Ethiopian-Jewish culture is based on a tribal cultural model. With their arrival in Israel, many difficulties inherent in transition from traditional village culture to Western society surfaced (2). Ethiopian Jews had to deal with cultural choices that challenged their traditions. It has been shown that immigration is associated with increased risk of mental and physical health problem. (3). Among Operation Moses immigrants, a parallel appeared between the trauma of the immigration process, the interface with Israeli reality and the appearance of symptoms such as anxiety, depression with suicidal ideation, and sleep disturbance. Arieli and Ayeheh (4, 5) concluded that the trauma of the journey coupled with the difficulties of the adaptation process to Israeli society (“minority status” and difficulties due to the language barrier), “the culture shock,” was directly responsible for psychopathology found among this population. Brief reactive psychosis was the most common severe psychopathology accounting for psychiatric hospitalization (6). Another issue was the non-readiness of clinicians in the face of unfamiliar clinical phenomena including brief psychotic episodes among members of a traumatized group in place of a classical PTSD picture (6), dissociative reactions with stupor and trance-like states lasting minutes to hours among adolescents (7, 8) and eating arrest (with no connection to anorexia nervosa) in the context of social distress (9). The incidence of both suicidal behavior and general practitioner visits for somatoform disorders has been noted to be inordi-

nately high in this population as compared to the general Israeli population (10, 11). Most who have written on the subject would agree that culture plays a central role in the construction of the clinical picture, blurring at times the boundary between idioms of distress and pathology.

Thus the issue of communication between medical practitioners, including psychiatrists, and patients coming from developing countries has become critical for those taking care of the Beta-Israel community. Studies have shown that many patients with psychiatric problems are not diagnosed as such in primary care clinics. Rather, it becomes manifested as a patient-doctor communication gap due to differences in cultural background and thus differences in the definition of illness and its expression (12)

In a world of immigration and breakdown of social cultural barriers, it becomes increasingly difficult to draw the line between culturally normative behavior and psychopathology. The following case report underlines a further aspect of the importance of socio-cultural considerations in both staff and patients, and illustrates the dangers of misdiagnosis due to patient-therapeutic team cultural clash.

CASE REPORT

Mrs. S, a 41-year-old woman of Ethiopian origin and mother of eight children (the last born six months prior to hospitalization) was brought to the psychiatric emergency room by a male social worker of Ethiopian origin. He diagnosed an "acute psychotic paranoid state," with suspicion of schizophrenia. Symptoms included sleep disturbances, wandering behavior outdoors at night, ideas of reference as well as paranoid and bizarre delusions: she believed that her husband wanted to kill her based on the fact that he had brought home a bottle of wine in addition to recently buying her a gift of a purse. Mrs. S said that in the past her husband would never have done such a thing and that she sensed that the wine and the present had negative magical properties. The family was not known to social services as problematic and the social worker did not report on past marital conflict or violence. Furthermore, at the time, there was no concern as to the mother's capacity to function as a parent. He did not report any changes in Mrs. S's behavior that could indicate any possible post-partum psychopathology. As he emphasized, it was Mrs. S who turned to him asking for help.

Since the patient did not speak any Hebrew, the initial ward intake took place in front of all the staff with

the help of a translator. There was a striking contrast between the patient's behavior, her answers and the so-called "psychotic content." The patient explained that she would never leave her home while there was nobody there to watch the children, thus all her attempts at escape were made at night. Mrs. S at all times remained calm, answered in an organized way, was oriented with mood congruent responses and was able to cope with the frustration caused by the language barrier. She was offended that the help provided was labeling her as a "lunatic" as she believed her distress was caused by a deteriorating marital relationship. She was disappointed by the attitude of the social worker as she expected him to find a solution for the couple instead of sending her to the hospital. While we were trying to develop a discussion of her marital life, she seemed reluctant to speak and her answers became laconic. The only reference made to the so-called "psychotic thoughts" was when the team tried to mull over with her a solution to her marital conflict. Mrs. S was interested only in separation, her reason being her husband's "death wish" toward her. When Mrs. S was further interviewed by the "white female" doctor who was assigned to treat her (once again with the help of a translator) she described her situation in more detail: she complained about a change in her husband's behavior since the birth of their eighth child six months earlier. The husband's lack of interest in her was obvious. He neglected to visit her in hospital and was absent when she was discharged from the obstetric ward. He did not provide for his family needs and proceeded to empty the family bank account without explanation. But she held on to the "psychotic" explanation as the reason why her husband wished for her death and tried to put her under a spell. The eldest daughter of Mrs. S was contacted and confirmed the patient's complaints concerning the status of the marriage, the financial situation and the husband's behavior at the time of the last childbirth.

The staff observing Mrs. S in the ward during the next few days noticed her well-adjusted behavior and the whole team agreed that there was no evidence indicating the existence of a psychotic state. Her ADL functioning was high compared to the rest of the ward. Her affect was congruent, behavior organized and appropriate, with no sign of agitation, hallucinatory behavior or signs indicating presence of paranoid thoughts or disorganized thoughts (as reported by Amharic speakers in the team). Though Mrs. S didn't speak Hebrew she could relate to the staff and turn to Amharic speakers

when they were on duty. Her concern with the wellbeing of her children was the main issue discussed apart from her will to separate from her husband. The theme of witchcraft, the “paranoid core,” was not expressed unless she was specifically asked what her reasons for separation were.

The option that the whole situation resulted from a misunderstanding based on cultural differences seemed more and more appropriate. In order to further verify current clinical status, a female nurse of Ethiopian origin was consulted to further evaluate Mrs. S. This evaluation took place without the presence of any member of the staff that could represent the “Western medical” establishment orientation. The nurse was aware of the psychotic thoughts expressed by the patients in previous examinations. During this conversation, Mrs. S did not mention any magic spells or any of her husband's homicidal intentions, but she did refer to many details regarding her prolonged marital problem (husband's lack of responsibility toward the family, financial concerns, etc.). The nurse maintained that Mrs. S did not express any psychotic thoughts, and the only answer provided to explain the so-called psychotic content was her wish to divorce from her neglecting husband. Mrs. S explained her attempt at escaping the house as a way to express her wish to leave the area where she was living with her three youngest children and move closer to her oldest daughter. The Ethiopian origin nurse confirmed the team's suggestion about the potential role that the cultural background could play.

Several attempts were made to contact the husband, urging him to contact the ward, all without success. The situation was reported to the social worker. Mrs. S's reaction to her husband's lack of cooperation was appropriate. She expressed deep disappointment concerning his neglect of the family and not paying attention to the fact she was hospitalized. However, she did not resort to any psychotic interpretation of his behavior. Furthermore, she did not understand his indifference as a confirmation of his criminal wishes but rather as an example of his lack of interest in the family wellbeing.

The eldest daughter was willing to receive Mrs. S with her youngest children and affirmed that there was room for her mother in the absorption center where she lived with her own family. After less than a week in the ward Mrs. S was sent for a trial in her new environment, with the agreement of the absorption center director who was made aware of the complex situation. The social worker was advised that the core-problem seemed to be

on the social/marital level and that treatment in an acute psychiatric ward was of no current benefit. It was also specified that Mrs. S was not interested in any further psychiatric intervention, but requested help with her marriage. It was suggested to the social worker to try and convince the couple to meet in a less stigmatizing environment than the hospital and have them treated by a family therapist in an ambulatory capacity.

Following a successful experience in the absorption center and no further reports of any pathological behavior, she was discharged after two weeks. Mrs. S did not receive medication of any kind during the hospitalization and there remained no indication to prescribe drug treatment at discharge. It should be noted that despite firm recommendations to maintain follow-up, the patient decided unilaterally that there was no need to any further treatment. Despite the team's misgivings on this issue, this decision was respected.

DISCUSSION

It is now well known that the communication gap between doctors and immigrants is due not only to language barriers but also to differences in defining illness and to beliefs about health and illness. These factors contribute to difficult encounters between medical practitioners and members of the Ethiopian immigrant community. The Israeli medical system is heavily influenced by Western cultural assumptions. Western culture is based on concepts like mind-body duality and scientific objectivity, whereas in many non-Western cultures, illness is viewed and treated in an integrated way that involves the body, mind, spirit, community, family and cosmos (3, 12).

Furthermore, Ethiopian culture, similar to other cultures, provides a cognitive map characterizing the members of the community. It comprises a framework of orientation of values, knowledge, belief and verbal and non-verbal language facilitating processes of reciprocity, mutual aid and a feeling of security (13). Social representations are a social group's common knowledge of language, images, ideas, values, attitudes, actions, orientations, norms and behaviors. Some beliefs might appear to an outsider (such as a clinician from a different cultural background) to be improbable while they are accepted within a specific cultural frame of reference. Henry Murphy, an early cultural psychiatrist, termed those beliefs “delusory cultural beliefs” (14). Studies show that social representations are quite stable and are constructed with a core and a periphery (15). The non-verbal transla-

tion of intimate feelings represents one of the cultural norms of the Beta-Israel community (16).

The case of Mrs. S is of particular interest because it comes in contrast to the knowledge regarding expression of psychological distress among members of the Ethiopian immigrant community in Israel. Somatic complaints among members of the Beta-Israel often represent the bodily expression of an emotion. There was no translation of the emotional problem into physical problems: the clinical picture was not built with the traditional and now known somatic complaints that usually are the expression of psychological discomfort such as a feeling of burning in the chest and/or the stomach, headache and generalized unlocalized pain (17). In addition, her complaint did not take the form of a classic Zar possession which is the name given to a certain category of spirits responsible in Eastern Africa for many physical and mental diseases. Certain situations are seen as particularly attractive to the Zar, especially when related to social-psychological stressors (10, 11, 18). The Ethiopian immigrant community in Israel is in the midst of an integration process and is still considered by many other Israelis as a separate group. It is clearly difficult to define normality in a community which is undergoing rapid change. With migration traditional patterns lose their significance, the old systems fail and new crises define fresh groups of vulnerable people. Standards of normality and abnormality change. Behavior once accepted as desirable becomes unusual if not reprehensible. Individuals may be forced to use quite different standards of behavior at the same time resulting in a confusion of roles (19).

The possibility that Mrs. S suffered from post-partum pathology was soon eliminated. Her last delivery did not qualify as a traumatic experience due to the differences between the Israeli approach to the delivery process (mainly bio-medical) and the traditional Ethiopian childbirth practice as it was not her first delivery in Israel. Though delivering a baby in Israel was described as a lonely and isolating experience lacking personal control and modesty (in contrast to the traditional experience allowing a woman in labor to chose female family members and neighbors as her personal circle of support), Mrs. S, similar to other women of Ethiopian origin, have come to trust Israeli health care providers in the field of obstetrics based on experience (20).

Our attention was drawn to the striking contrast between the so-called "psychotic syndrome" and the behavior of the patient in the ward that did not match

a classic psychotic disorder diagnosis. We understood the difference of attitudes toward the social worker, the doctor and the nurse as dictated by socio-cultural factors. Psychotic thoughts as expressed by Mrs. S were understood as a mode of expressing a given psychological and existential state. Every idiom of distress is based on cultural symbols, but the way in which these symbols are employed on a given occasion may be idiosyncratic (21). The use of psychotic thoughts by members of the Ethiopian immigrant community is less frequent in a context of social-psychological distress, though in such a culture, it might be that an individual with predisposing personality traits would react to extreme stress by exhibiting an exaggeration of the culturally accepted response in form of a brief reactive psychosis (6). As hypothesized, the fact that the nurse was female and belonged to the same community assisted Mrs. S to talk with no reservations. Mrs. S might have been reluctant to talk openly of her marital problem to a male of Ethiopian origin despite him being a social worker just as she may have been suspicious of a white physician despite her being a female. With an appropriate interlocutor, a female Ethiopian immigrant nurse, she did not need any codes and symbols. Furthermore, in this case, as noted by Murphy, distinction between delusions and culturally held belief cannot be made by belief content alone but rather due to the low intensity of belief (14).

This case underlines the potential dangers of the psychiatric diagnostic process in an immigrant community. To use a diagnosis is to try to condense the vast amount of information we find out about someone. Picking a single label is felt to lead to a dehumanized and isolated conception of the individual with an inadequate picture of her feelings and experiences (19).

Additional factors accounting for the misdiagnosis of the Ethiopian immigrant social worker include his role not only as a translator, but also as a cultural mediator. Thus it could be that his life in Israel, his studies at the university and his integration process played a role in this case. Young people from the Ethiopian immigrant community in Israel lack grounding in traditional Ethiopian culture and might lack certain finesse characterizing his community of origin, while not yet rooted in the Israeli culture and familiarity with Western psychiatric jargon (17). It could be due to the fact that adopting the values of a new society involves discarding the old, as discarding "superstitions" enables the successful immigrant to measure his integration against his "primitive" compatriots. Mrs. S expressing herself with

such a traditional belief as the belief in witchcraft may have been a serious threat to his own efforts of integration (19). Furthermore, the possibility of him having a subconscious reluctance to preserve a certain frame of social codes, which are in contradiction with the dynamic of change his community and he personally may be experiencing, should not be dismissed.

The issue of the psychiatrist's attitude to the minority patient is not less important. Are their backgrounds and education likely to make them particularly sympathetic to psychological difficulties in ethnic minorities? A psychiatrist's attitude to the minority patient is known to be formed by his own personal issues, conscious or unconscious biased assumptions and the particular setting in which the two meet. Outsiders challenge our tendency to see our society as the natural milieu and ourselves as the measure of normality (19). It might be that the heterogeneity of the ward team (four to five different ethnic backgrounds) made possible the avoidance of an ethnocentric approach to Mrs. S case.

Observations from this case report emphasize the important role of socio-cultural background of both staff and patients in patient management and encourage the consideration of cultural factors in all patient evaluations.

References

1. State of Israel Central Bureau of Statistics. 2010
2. Rosen H. Ethiopian Jews: A historical sketch. *Isr J Med Sci* 1991; 27: 242-243.
3. Reiff M, Zakut H, Weingarten MA. Illness and treatment perceptions of Ethiopian immigrants and their doctors in Israel. *Am J Public Health* 1999; 89: 1814-1818.
4. Arieli A, Aycheh S. Psychopathology in Ethiopian Jewish immigrants. *Harefuah*. 1991; 121: 417-421 (Hebrew).
5. Arieli A, Aycheh S. Psychopathology among Jewish Ethiopian immigrants to Israel. *J Nerv Ment Dis* 1992; 180: 465-466.
6. Grissaru N, Irwin M, Kaplan Z. Acute psychotic episodes as a reaction to severe trauma in a population of Ethiopian immigrants to Israel. *Stress Health* 2003; 19: 241-247.
7. Ratzoni G, Apter A, Blumensohn R, Tyano S. Psychopathology and management of hospitalized Ethiopian immigrant adolescents in Israel. *J Adolescence* 1988; 11: 231-236.
8. Ratzoni G, Ben Amo I, Weizman T, Weizman R, Modai I, Apter, A. Psychiatric diagnoses in hospitalized adolescent and adult Ethiopian immigrants in Israel. *Isr J Med Sci* 1993; 29: 419-421.
9. Ben-Ezer G. Anorexia nervosa or an Ethiopian coping style? *Mind Human Interaction* 1990; 2: 36-39.
10. Witztum E, Grissaru N, Budowski D. The Zar possession syndrome among Ethiopian immigrants to Israel: Cultural and clinical aspects. *Br J Med Psychol* 1996; 69: 207-225.
11. Grissaru N, Budowski D, Witztum E. Possession by the "Zar" among Ethiopian immigrants to Israel: Psychopathology or culture-bound syndrome? *Psychopathology* 1997; 30: 223-233.
12. Youngmann R, Zilber N, Kaveh N, Zere M, Worknesh F, Bekele Y, Giel R. Development of a culturally sensitive psychiatric screening instrument for detecting emotional problems among Ethiopian immigrants in Israel. *Harefuah* 2002; 14: 10-16 (Hebrew).
13. Durst R, Minuchin-Itzigsohn S, Jabotinsky-Rubin K. "Brain Fog" syndrome: Manifestation of transculturation in an Ethiopian Jewish immigrant. *Isr J Psychiatry Relat Sci* 1993; 30: 223-232.
14. Murphy HBM. Cultural aspects of the delusion. *Studium Generale* 1967; 10: 684-692.
15. Levin-Rozalis M. Social representations as emerging from social structure: The case of the Ethiopian immigrants to Israel. *Papers on Social Representations* 2000; 9: 1.1-1.22.
16. Friedmann D, Santamaria U. Identity and change: The Falachas between assimilation in Ethiopia and integration in Israel. *Arch Europ Sociol* 1989; 30: 90-119 (French).
17. Youngmann R, Minuchin-Itzigson S, Barasch M. Manifestations of emotional distress among Ethiopian immigrants in Israel: Patient and clinician perspectives. *Transcult Psychiatry* 1999; 36: 45-63.
18. Kahana Y. The Zar spirits, a category of magic in the system of mental health in Ethiopia. *Int J Soc Psychiatry* 1985; 31: 125-143.
19. Littlewood R, Lipsedge M. Aliens and alienists, ethnic minorities and psychiatry. London and New York: Routledge, Third edition, 1999.
20. Granot M, Spitzer A, Arian K J, Ravid C, Tamir B, Noam R. Pregnancy and delivery practices and beliefs of Ethiopian immigrant women in Israel. *Western J Nursing Res* 1996; 18: 299-313.
21. Witztum E, Goodman Y. Narrative construction of distress and therapy: A model based on work with ultra-Orthodox Jews. *Transcult Psychiatry* 1999; 36: 403-436.