A Vietnamese Man with Selective Mutism: The Relevance of Multiple Interacting `Cultures' in Clinical Psychiatry

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ARTICLE

A Vietnamese Man with Selective Mutism: The Relevance of Multiple Interacting 'Cultures' in Clinical Psychiatry

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Abstract Multiple cultural variables have effects on the psychobiology and behavioral manifestations of illness, as do patient and physician perceptions of illness. The interaction among these variables is at the heart of clinical psychiatry. This case of a Vietnamese man with selective mutism underscores the relevance of the 'cultures' of medicine, psychiatry, and war and trauma on the manifestations of illness and illness perceptions by patient and physician. The discussion focuses on how these cultures interact and play a crucial role in formulating diagnosis and treatment planning. Suggestions are given for shifts in medical education that will encourage relevant cultural paradigms to make their way into educational and clinical systems, which in turn should improve cultural competence in clinical psychiatry.

Key words clinical measurement • culture • medicine • methods • psychiatry • transcultural • trauma

In this article we present the case of a Vietnamese man who was brought to a university hospital after experiencing a series of social insults, displaying behavior that appeared psychotic. Repeated and diverse attempts to establish communication were frustratingly unsuccessful. The treatment team was deeply dissatisfied with the lack of clarity in the diagnosis and the direction of the case, as the patient remained unable to care for himself

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and was at risk of commitment to the state hospital. A cultural consultation was obtained to help re-think diagnosis and treatment. The case provides the framework for an examination of the layers of overlapping cultures that comprise an individual, the medical culture that we as physicians operate within in our practice, and the way in which these interact in assessment and treatment planning.

History, Examination, and Initial Diagnoses

The patient discussed here gave verbal informed consent to publish the information below. The authors have included details important to the case and the discussion, but have deleted and changed other details to protect the privacy of this patient and his family.

A Vietnamese man in his forties (hereafter 'BN') had been a relatively unnoticed inmate in a county detention center for a week on a domestic violence charge when, during his arraignment, he was mute and defecated in the courtroom. He was transferred to the University Mental Health Center (MHC) in-patient unit for evaluation. There had been no forensic psychiatric evaluation and information about the details of his arrest or his time in jail was sparse.

BN rarely spoke, and when he did it was soft and often unintelligible. The hospital Vietnamese translator was acquainted with BN and reported that the patient had always been quiet, withdrawn and with few friends. According to the translator, BN had been in the US for two decades, had worked in a jewelry shop and had married and fathered a child 2 years previously. The translator believed that the wife had left the patient and taken their child because of alleged domestic violence. On one occasion BN supposedly indicated through the translator that he had worked hard, earned money for a car and a wife and had now been betrayed. BN once said that he had '. . . been violently arrested and felt devastated.' No further information about BN's personal or family psychiatric history could be obtained. His developmental history and life events were essentially unknown, and his medical history was notable for diabetes mellitus of unknown duration or treatment. During the psychiatric emergency service intake, BN reportedly said that he was suicidal.

Examination on the ward revealed a thin malodorous Asian man with poor dentition who looked older than his recorded age. He was 5 feet 5 inches tall, appeared to weigh about 120 lbs, with a blood pressure of 147/94, a pulse of 112 and an oral temperature of 98.5 (C. He was lying in bed, moving very slowly and making almost no eye contact. BN's mood could not be assessed, his affect was flat, and his rare speech was usually too soft to hear. His thought process and content were difficult to evaluate, though the interpreter reported 'disconnected nonsense.' Formal cognitive testing was not possible, and his insight and judgment were thought to be impaired.

He consistently refused to allow a full physical examination to be performed.

Laboratory studies were notable for a non-specific ECG T-wave abnormality, a specific gravity of 1.035 and glucose of >1000 mg/dl on urinalysis, serum glucose of 199 mg/dl, BUN of 27 mg/dl, serum calcium of 8.5 mg/dl, and HgA1C of 11.5%. All other electrolytes were normal, as were his TSH, RPR, CBC and his negative urine toxicology.

BN was admitted for safety and further evaluation for diagnosis and treatment. The initial preliminary diagnosis – based on the signs of self-neglect, marked withdrawal, flat affect, poverty of speech and disorganization of thought – was psychosis not otherwise specified. The differential diagnoses included schizophrenia, major depression with psychotic features and acute stress disorder. The clinical presentation was not fully consistent with catatonia, but the option of administering antipsychotic and benzodiazepine medication and/or electroconvulsive therapy were future treatment considerations.

Hospital Course

On day 1 lorazepam was administered on an emergency basis, as BN appeared more catatonic. His oral intake was poor, he continued to be selectively mute, nearly immobile, and minimally responsive to external stimuli, refusing all testing and medication, with the possibility that this behavior was purposefully oppositional rather than catatonic negativism. Hyperglycemia, hypoglycemia and dehydration were other factors that were considered as being potential etiologies for his mental status abnormalities.

BN was deemed incapable of informed consent and petitions to administer emergency therapies and for a treatment guardian and hospital commitment were filed. BN was court committed for a 30-day involuntary admission and a treatment guardian was assigned. He was prescribed sertraline, 25 mg every morning, haloperidol, 5 mg every day, and benztropine mesylate, 1 mg twice a day; he most often refused all medications. Liquid fluoxetine was substituted for the sertraline to improve compliance, and eventually was increased to 30 mg per day.

The hospital Vietnamese translator visited BN nearly every day but BN continued to be minimally and intermittently communicative. The resident psychiatrist (CG) saw him several times a day for the duration of his stay. Over the first two weeks, BN gradually became more cooperative with procedures, improved his oral intake and hygiene, and was more behaviorally responsive. However, he stayed in hospital pajamas and would not dress unless staff intervened, and he did not participate in ward activities. He was frequently seen talking when he was alone, and his responses to questions remained monosyllabic. BN's medication compliance seemed to improve, but during the second week numerous pills were discovered in his bed. He twice was heard saying that he was afraid of being in the hospital

and he thought that the staff 'would hurt him.' Early in his stay, BN had a male visitor from the community who reported to staff that BN had been controlling of his wife, confining her to their home, and had spent a lot of time talking while staring at himself in the mirror.

A Cultural Consultation

Days before the patient was to have a hearing for an extended involuntary commitment to the State Hospital, the attending (CF) and resident (CG) in-patient physicians asked for a clinical cultural consultation. The in-patient team was concerned about the poor communication with the patient and the consequent lack of a clear diagnosis, and wanted input about other clinical approaches that might help with communication, diagnosis and treatment planning. The first author (MH) is trained in psychiatry and family medicine, practices in a clinic with a large Vietnamese population, and also conducts research about the health outcomes of trauma in Vietnamese and Kurdish refugees. His research team has extensive experience interviewing traumatized refugees with a translator. MH was accompanied by YJ, a trusted member of the local Vietnamese community and an experienced translator and research assistant for MH's research team.

MH and YJ were joined by the resident psychiatrist (CG) for the interview. BH was in his bed, awake, moving very little, in a room with three other patients. MH and YJ approached BN and asked to speak with him, but BN said nothing. YJ, who had been the translator for BN in the in-patient commitment hearing (during which BN had been mute), explained to the patient her role in and the reason for the research and for the consultant's visit. She continued to tell BN about the research team's interest in the story of refugees, and how their experiences have affected their health. BN began to nod, and spoke quietly to YJ. The consultant asked BN if he would come to another, private room to talk, but BN shook his head 'no' and said that he preferred to stay in his bed. He sat up on the side of his bed facing YJ.

Any questions about what had happened with his wife, in jail, or in court were generally met with silence from BN. Attempts to ask him about current symptoms were also not fruitful. BN had a paucity of speech and movement, and appeared to be either very anxious or attending to internal stimuli. Thus, the consultant began a different, 'life narrative approach,' by engaging BN in a discussion about where he had been born and raised in Vietnam, and about how his life unfolded during the Vietnam–U.S. war. After halting speech for the first few minutes, BN began to disclose information of his early life. Continuing this life narrative approach resulted in a vibrant exchange for 20 minutes, during which BN became more animated, linear and with appropriate content and affect. When the life narrative interview approached the year 1975, BN told how, two weeks after the fall of Saigon,

Vietnamese communists stormed his home, interrogated him, seized his belongings, and violently arrested him. BN said that this is exactly what happened one-month prior to this interview, when the police came to his house with his wife and her male friend, served him with a restraining order, seized his belongings, and arrested him. Direct questions about this event or current symptoms again resulted in BN's becoming quiet, withdrawn and slightly disorganized, and relaying less information than during the narrative. Thus, the interview was refocused on the life narrative, and BN again became animated, open and understandable as he told of his two years in a refugee camp where he lost 40 pounds because of hard labor and malnutrition. In the refugee camp BN had experienced nightmares, hypervigilance symptoms, mild avoidance of traumatic thought content, and occasional hallucinations. These symptoms had largely abated since he had come to the US, although depression and need for control began to dominate his life.

Signs and symptoms in the context of the life narrative were consistent with acute stress disorder and major depression, severe, with a history of post-traumatic stress disorder (PTSD). A primary psychotic disorder was not thought to be present because of the rapid change in speech to a linear pattern, with appropriate thought and behavioral content to the interview. Isolated psychotic symptoms such as hallucinations or paranoia could not be definitively ruled out and would nonetheless be consistent with acute stress disorder in this context. The consultant recommended that antipsychotic medication be discontinued and that the selective serotonin reuptake inhibitor be increased to a moderate to large dose. Essential to treatment was that BN be provided education and treatment options, that the in-patient team negotiate with BN a voluntary treatment plan, and that BN only be detained for exceptional clinical circumstances. Detention and coercion, two factors involved in the genesis and manifestation of BN's PTSD and the acute illness, would likely cause iatrogenic harm. The treatment team, placed in an ethical conflict between individual patient treatment needs and potential social legal considerations, was obligated to choose in favor of the treatment imperative by not repeating the retraumatization of detention and coercion of an involuntary commitment.

The petitions for a treatment guardian and commitment were canceled as BN agreed to stay as a voluntary patient. Antipsychotic medication was discontinued, and the antidepressant was increased. YJ and CG met with BN every other day and began to unravel the psychiatric and psychosocial history. YJ interviewed BN's wife and her family, who all denied that the patient had been physically abusive. The marriage was according to custom, although not a legal union in the US. BN's wife did not want to continue living with him, and had moved with their child to her parents. She said she was afraid of BN and that she did not want to be controlled by him. BN's wife and her male friend began demanding that the hospital give them BN's

money and belongings, and insisted that BN be kept in the hospital or in jail. They became quite agitated when their requests were denied, were escorted by security out of the hospital, and were subsequently banned from the ward.

BN soon began attending groups (though speaking very little), interacting with the translator and became compliant with medication. He went out on pass and returned volitionally. On the day of discharge he was ambivalent, and was mostly concerned about wanting to have his 'seized' belongings returned to him. An apartment was arranged for him and community members offered to look in on him. His money was placed in a bank account and his car keys and belongings were retrieved from the wife's friend. He was scheduled for follow-up in a clinic which serves many of the Vietnamese in Albuquerque with translators and clinicians familiar with the Vietnamese population.

Discussion: Three Cultures and Their Impact on Assessment and Treatment

Webster's New Collegiate Dictionary (1974) defines culture as 'the integrated pattern of human behavior that includes thought, speech, action, and artifacts and depends upon man's capacity for learning and transmitting knowledge to succeeding generations,' and 'the customary beliefs, social forms, and material traits of a racial, religious, or social group.' The perspective of Kleinman that the accuracy of clinical assessment and treatment are 'all caught up in a reciprocal relationship between the social world of the person and his body/self (psychobiology)' (Kleinman, 1988, p. 3) underscores the relevance of the cultural formulation to clinical assessment and management in this case study. The symptoms experienced by BN and his interpretation of them were inextricably linked to his socio-political experience during the war. Kleinman proceeds to suggest that there are multiple cultural interactions whereby psychiatry as a social institution (and thus one of the 'cultures') also participates in this dialectic, because psychiatric diagnoses are constrained not solely by biology, but also by the social and historical context in which diagnostic structure has spawned. The clinical signs seen and interpreted by American psychiatrists were linked to their professional cultural experience, in essence, to what data are collected and how they are collected and interpreted.

Medicine and psychiatry are cultural constructs that interact with the culture of the patient in formulating clinical assessment, diagnoses and their implied treatments. Furthermore, the beliefs and social forms created by the particular war and events experienced by BN are more relevant in this case than BN's ethnicity. Ethnicity may be associated with many customary beliefs, social forms, and material traits, and thus to 'culture,' but is often not the most important cultural domain in clinical medicine.

For example, the range of personality traits seen in any ethnic–social group is greater than the difference in average personality traits between ethnic groups (Bhugra, Corridan, Rudge, Leff, & Mallett, 1999; Leff, 1993). The general phenomena of war trauma and later re-traumatization were the primary socio-cultural forms responsible for BN's illness, not the fact that he was Vietnamese. There were certainly other aspects of his being Vietnamese – such as the traditional relationship and ideas about money, familial hierarchies and ownership – that were important to his personhood and clinical status. However, BN's illness originated primarily from trauma contextualized by the Vietnam–U.S. war, and the multiple betrayals and their mnemics that he experienced were more powerful predictors of his clinical status than his ethnic origin. Furthermore, the way that American medicine and psychiatry are taught and practiced were important, interactive cultures that affected caregiver's perceptions about BN's illness and his treatment.

Culture 1: American Medicine

Fabrega (1996) writes that western medical culture values a certain kind of scientific paradigm that has given progressive authority to impersonal biomedical constructs of health and disease over concepts of health and illness that accept and incorporate situational and personal characteristics of the individual. This value has worked its way into the most basic structure of American medicine, defining what data are important, and how they are to be obtained and interpreted. As a result, American medical schools teach interviewing that tends to align developing physicians more with obtaining data about the illness than about the person who has the illness, implying that data collection about non-contextualized signs and symptoms will suffice for understanding what is wrong with the patient. The effects of this cultural position on clinical management were seen in the case of BN. Questions designed to elicit current events and symptoms not only failed to provide information, but also resulted in signs – withdrawal and mutism – that confounded diagnoses and treatment. With this patient, asking questions about events and symptoms in a way that he interpreted as interrogation served as a re-traumatizing event. Thus, these questions were met with the logical and conditioned, protective response of not hearing and not talking: 'I will not be heard, so I will not speak.' This theory was empirically proven in the consulting interview. When the clinician adopted a narrative approach to align more with the patient as person than with the impersonal biomedical and social notions about recent events and symptoms, new data emerged. This technique paradoxically resulted in more and different information about current symptoms and signs than did direct questioning, and thus in different and more

appropriate diagnoses and treatment plans. Any attempt on the clinician's part to revert to an 'interrogative' style resulted in BN reverting to an interrogated, traumatized patient. The clinician's different cultural styles and behaviors interacted with the clinical status of the patient, demonstrating how the medical culture can provide a lens through which doctor views and interprets the patient (Fire & Erdoes, 1994).

Culture 2: American Psychiatry

The customary belief that data collection about non-contextualized signs and symptoms is adequate to understand the patient and his illness is particularly dangerous in psychiatry, where pathogenesis is inarguably influenced both by an ongoing socio-cultural fabric and a biogenetic substrate. Except for organic brain disorders and substance use disorders, there is convincing evidence that only four psychiatric disorders – schizophrenia, bipolar disorder, major depression and a group of related anxiety disorders – are distributed worldwide, and that the remaining adult mental disorders are specific to various geographic regions and countries, implying variability regarding the relative influences of biological, psychological and socio-cultural factors in the genesis of most psychiatric illnesses (Kleinman, 1996). There are many examples of how socio-cultural variables are associated with misdiagnosis and improper treatment, especially in minority and vulnerable populations (Good, 1993; Neighbors, Jackson, Campbell, & Williams, 1989), such as African Americans being disproportionately diagnosed with schizophrenia instead of bipolar affective disorder (Good, 1993) or the effects of gender on the misdiagnosis of borderline and antisocial personality disorders (Nehls, 1998; Rutherford, Alterman, Cacciola, & Snider, 1995). There is an extensive literature describing how culture influences patients' experience of psychopathology, the clinical manifestations and course of psychiatric illness, diagnosis, treatment and treatment outcomes (Fabrega, 1987; Kleinman, 1988; Mezzich & Berganza, 1984; Rogler, 1989). These data point to the fact that psychiatry and its clinicians are not exempt from the biases or variability imbued by this socio-cultural fabric. Western psychiatry has developed within the constraints of certain intellectual commitments about the ontology of disease, the emphasis on rational autonomy, the mechanistic philosophy in medicine and a view of the central nervous system as the substrate for the conceptual basis of mental illness (Fabrega, 1996). These intellectual commitments are the bedrock of a professional psychiatric culture that made it most likely that BN would be diagnosed with a psychotic disorder, seen as non-competent, and treated with medications to mend his broken nervous system and a hospital commitment in his 'best interest.' This most likely outcome was

in spite of the fact that it has been established that trauma can be associated with symptoms that appear to be psychotic, but which occur in a broader clinical context of disorganization during and after re-traumatization, and that systems other than the central nervous system also become restimulated and disorganized in their function (Van der Kolk, 1994; Zoellner, Goodwin, & Foa, 2000). Collecting and interpreting data within a contextualized life narrative paradigm allowed clinicians to establish more accurate diagnoses and treatment plans, resulting in improvement in the patient's psychobiological, behavioral and social functioning. Fortunately, there is an intellectual shift taking place in American psychiatry regarding knowledge about trauma and its symptoms, which was reflected in the 'rule out acute stress disorder' and the cultural consultation by the astute inpatient physicians in this case.

Culture 3: War, Trauma and the Person: Social and Interpersonal Shaping of Illness

People traumatized by war and political oppression are steeped in processes of anonymity, asymmetry, inequality, mistrust, and insecurity about time and place that are used to break mind and body (Doerr-Zegers, Hartmann, Lira, & Weinstein, 1992). Refugees who have lived in such situations for many years, as BN had, thus may not reveal themselves to people they do not know as a result of the mistrust created by trauma experiences in general and by the rational, learned mistrust of authority (Cirtautas, 1957; De Vries & VanHeck, 1994). In this way, the pathogenesis and course of mental illness are inseparable from ongoing social events, and are more of a social than natural process (Kleinman, 1996). This fact of pathogenesis is highly relevant for people who experience ongoing polytrauma, in which culture and political practice mediate the experience of violence (Scarry, 1985), and gender, class, and ethnic dimensions of violence are cultural constructs that also help determine how violence is structured, how it harms, and how resilience occurs (Jenkins, 1991, 1998; Kleinman & Desjarlais, 1995; Westermeyer, Bouafuely, Neider, & Callies, 1989). Furthermore, trauma type, symptoms and coping style may vary by gender and ethnicity (Allden et al., 1996; Allodi & Cowgill, 1982; Jenkins, 1998; Mollica, Wyshak, & Lavelle, 1987; Thompson & McGorry, 1995). For example, women may experience more sexual trauma than men (Allodi & Cowgill, 1982), and they do not easily talk about these events (De Vries & VanHeck, 1994; Westermeyer et al., 1989), as this may shame them and/or their families (Bonnerjea, 1985) and may produce somatic symptoms as a defense against the telling of the shame (Cheung, 1993).

Although war trauma and political oppression have common features across time through history, there are also different socio-political forces

working in each war context. In the Vietnam–U.S. war Vietnamese men were more likely than women to be imprisoned. In our illustrative case, this Vietnamese man had a history of severe traumatization contextualized by a specific war, including loss of autonomy and respect, loss of material wealth, betrayal, separation and isolation, displacement and physical detention and abuse. This long-standing social context of war and trauma was a process largely responsible for BN's illness, and the acute social stressor became symbolic re-enactments of this war trauma culture and determined the acute illness and its symptomatic manifestations.

Conclusion

Multiple socio-cultural variables have an impact on the pathogenesis of psychiatric disorders, the patient's experience of the illness, and the physician's assessment and treatment of the patient. For both patient and physician, the predominant social contexts become internalized as psychobiology, belief and behavior. The interaction between these respective cultures of patient and doctor is the heart of clinical assessment, diagnosis and treatment. Further acceptance by medicine and psychiatry of this principle as one of its important intellectual commitments will help educational and clinical systems become more culturally sensitive. If this paradigm shift occurs in medical education and practice, it will become less likely that a patient, particularly a vulnerable and marginalized one, will be misunderstood with resultant inappropriate diagnoses and treatments. Fortunately, this shift has begun to take form: The NIMH Culture and Diagnosis Group (Mezzich, Kleinman, Fabrega, & Parron, 1996) recommended a standard cultural approach for the DSM-IV, some of which was included in the manual.

These facts point to the imperative of respect for individuals in clinical medicine and psychiatry. The most accurate and culturally sensitive thing to do is to collect data about the individual in his or her social context, which may – but does not necessarily – include specific factors about ethnicity. Attempts to be culturally sensitive by assuming that individual characteristics will conform to ethnic group norms are a form of racism. The classic works of Rogers (1961) and Buber (1970) are highly relevant in this respect: accurate clinical assessment occurs when it is client-centered in the context of an authentic relationship. Accuracy is enhanced when the clinician is attentive to the patient as a person, so that trust and understanding allow the clinician to treat the person with the illness.

Epilogue

BN did not follow up in the clinic at his appointed time, although he did go to the clinic to obtain refills for medication for his diabetes. He is paying his rent on the first of every month in person at the apartment offices and has apparently remained quite isolated. He has been working as a cook in a popular restaurant for 3 months and is paying child support to his estranged wife. YJ states that BN's speech is logical, with normal volume and appropriate content, that he has gained weight, and is well groomed.

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