

CASES THAT TEST YOUR SKILLS

Mr. A and Mr. B are treated for depression with psychotic features after exhibiting apparent delusional behaviors. Their cases illustrate how ethnic and racial misperceptions can complicate diagnosis.

Psychosis or ‘cultural paranoia?’

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Culture-related anxiety and paranoia can be difficult to treat because they are reinforced by socially normative practices and beliefs.¹ As in the two cases described below, psychiatric patients with deep underlying mistrust may view a therapist from another culture—even though well-meaning—as a racist oppressor.

The clinician’s approach to therapy can help prevent cultural misunderstandings and—most important—misdiagnosis (*Box, page 70*).

MR. A’S CASE ‘She’s out to get me’

Mr. A, age 38 and African-American, was admitted to the inpatient psychiatry service with neurovegetative depressive symptoms and apparent delusional thinking.

His wife of 20 years, also African-American, was concerned that he was becoming increasingly irrational. She said he accused her of conspiring with his predominantly white supervisors to “bring about my destruction.”

Mr. A consented to admission, acknowledging to

the psychiatrist that he had felt depressed and at times considered suicide. He complained that he had recently experienced several unusual “happenings:”

- Pointing to recent weight loss, Mr. A feared someone was poisoning his food or that he had swallowed a “tracking” device.
- Mr. A feared that workers who were repairing flood damage in his home were sent to kill him. He remained home during the project, but the fear drove him to a panic attack.
- After more than 18 years working for the same employer with no notable interpersonal difficulties, Mr. A suddenly could not get along with his coworkers. He accused one colleague of following him to a restaurant.

Mr. A had no previous psychiatric disorder, but some distant relatives had schizophrenia. He was diagnosed as having major depressive disorder, severe with psychotic features; delusional disorder was ruled out. He was prescribed olanzapine, 10 mg at bedtime, and fluoxetine, 20 mg/d.

In the hospital, Mr. A spoke normally with no agi-

Box

4 tips to help you avoid cultural misunderstandings during therapy

- **Set treatment goals** at the start. Make sure you and the patient agree on these goals.
- **Make sure** the patient understands he or she can cease treatment at any time. Stress that you are there simply to help achieve the patient's stated goals.
- **Avoid direct** empathic statements during psychotherapy (eg, "You feel angry"); the patient may suspect you are imposing your beliefs. *Indirect* statements (eg, "It wouldn't surprise me if you felt angry") convey curiosity about the patient's reactions and invite further discussion.
- **Admit** when you do not understand a culturally specific colloquialism or mannerism, and ask the patient to explain it at the next session. This usually encourages the patient to keep the follow-up appointment.

tation, increased activity, or evidence of racing thoughts. In group therapy, he explained that he felt "confused." He also disclosed that a recent extramarital affair left him feeling extremely guilty.

A few days later, Mr. A's suicidal and paranoid ideations disappeared. He expressed anger only while discussing his diagnosis with the attending psychiatrist, who is white. The patient feared that being diagnosed with a psychotic illness would hurt his career. He admitted he felt depressed, but insisted that he now realized his paranoid thoughts were irrational.

Mr. A was discharged after 6 days. He remained on fluoxetine, 20 mg/d; olanzapine was discontinued due to excessive sedation.

The patient also entered insight-oriented psychotherapy to address his depression. Mr. A and the therapist, who is white, spent most of the initial sessions discussing their racial differences. At one point, Mr. A complained to the therapist that white

physicians were trying to "railroad" him because of his race.

After nine sessions, Mr. A revealed that he felt isolated at an early age, thinking that others "will use what they know about me against me." He described growing up in a predominantly black community where most of his neighbors felt oppressed by white people. As therapy progressed, Mr. A realized that this experience influenced his attitudes about race, and that his extramarital affair destroyed his sense of self-trust, which may have fueled his mistrust of others.

After 20 sessions, his marriage and work relationships were stable and his overall mood was much improved. His Outcome Questionnaire 45.2 score decreased across 12 months from 88 (moderate to severe distress) to 55 (level of distress similar to that of non-patients). Delusional behavior has not re-emerged, although his comments continue to reflect mistrust of his supervisors and of white people in general.

What would your diagnosis be? What clues would you gather from Mr. A's pretreatment behavior and from his progress in therapy?

Dr. Benzick's observations

Mr. A's diagnosis upon admission reflected the psychiatrist's belief that he suffered fixed delusions. By definition, however, a delusion is a false belief that is not "ordinarily accepted by other members of the person's culture or subculture."²

Growing up, Mr. A shared his neighbors' suspicion of white people. Further, his overvalued conspiracy theory involving his wife might

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have projected his own guilt over his infidelity onto a pre-existing paranoid personality.

Based on his psychosocial history, rapid progress in psychotherapy, and marked improvement in Outcome Questionnaire 45.2 scores, Mr. A does not have a personality disorder. What's more, paranoid ideation is not uncommon in African-Americans with depressive symptoms, as demonstrated by Bazargan et al.³

Mr. A's diagnosis was changed to major depressive disorder, moderate, in partial remission. He is still seen approximately every 6 weeks for medication maintenance; he continues taking fluoxetine, 20 mg/d.

MR. B'S CASE 'Singled' out

Mr. B, age 42 and African-American, was referred from an alcohol rehabilitation program to the psychiatry unit after exhibiting depressive and paranoid symptoms.

After 17 years with his employer, he started clashing with his supervisors and coworkers—most of whom are white. He claimed his colleagues were talking behind his back, jealous that he is single and spends his evenings at nightclubs. He alleged that his bosses were singling him out after he was transferred to another department and reprimanded for arriving late to work. Resultant worry about job security brought on panic symptoms (shortness of breath, lightheadedness, dissociative feelings, and palpitations).

Upon further questioning, Mr. B said he felt depressed and isolated. He had been prescribed nortriptyline 2 years ago but discontinued it after a few weeks because of side effects.

Mr. B said that not having a steady companion contributed to his depression and alcohol use. He had been drinking heavily for about 3 years, consuming at least a six-pack daily. He acknowledged that his suspicion of his white coworkers long pre-

ceded his alcoholism. Still, he did not see this mistrust as a problem.

Mr. B was diagnosed with major depressive disorder, severe with psychotic features. Treatment consisted of:

- paroxetine, 20 mg/d
- attendance at Alcoholics Anonymous meetings (at least three meetings per week were recommended)
- and 12 sessions of interpersonal psychotherapy. During these sessions, the therapist began to uncover the roots of Mr. B's symptoms.

School days. Mr. B described how, as a little boy, he once watched his mother being beaten by his drunken father. He told the therapist that the beatings occurred frequently.

When he was age 5, Mr. B's parents divorced and he and his mother moved to a mostly white Midwest neighborhood so that he could attend a high school with an advanced music program (he was honored for exceptional talent on several instruments).

In his youth, Mr. B's mother repeatedly told him that teachers and students would treat him "differently" because of his color, though she never explained what she meant. While in high school, he began to worry about his social functioning, appearance, work performance, and future accomplishments.

After four psychotherapy sessions, Mr. B revealed that while in grade school, he was sexually assaulted by an older white boy. For more than 30 years, he had told no one. He denied hyperautonomic and re-experiencing symptoms but realized that this incident may have kept him from starting a romantic relationship.

After psychotherapy, Mr. B reported reduced depression and increased social interaction. His Beck Depression Inventory score dropped from 23 (moderate depression) to 4 (normal mood), and his

Deep-seated cultural perceptions and past trauma together can cause severe anxiety

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Beck Anxiety Inventory score improved from 33 (moderate anxiety) to 3 (very low anxiety). He has been sober for 6 months and handles stress more effectively, although his mistrust toward coworkers is still apparent.

How would you diagnose Mr. B? Do his symptoms characterize "psychotic features" or an anxiety or alcohol-related disorder?

Handwriting lines for the first question.

Dr. Benzick's observations

Mr. B's case illustrates how deep-seated cultural perceptions and past trauma together can cause severe anxiety—and how that anxiety can be misperceived as psychosis. Anxiety also can manifest as paranoia in "psychotically vulnerable" individuals.

Chronic anxiety seemed to cause Mr. B's depressed mood and social withdrawal. Several anxiety disorder diagnoses were considered, including:

- panic disorder
• posttraumatic stress disorder
• social phobia
• alcohol-induced anxiety disorder
• and generalized anxiety disorder.

Mr. B, however, exhibited no evidence of repeated episodic anxiety, nor did he describe re-experiencing phenomena. His anxiety extended beyond social situations and preceded his heavy alcohol consumption. Paranoid personality disorder was also considered, but Mr. B sought relationships and lacked the angry, unforgiving qualities associated with this pathology. Finally, a bat-

tery of psychological tests did not reveal frank psychosis but suggested an avoidant personality style.

Mr. B's diagnosis was changed to generalized anxiety disorder. He requested a trial off medications during the latter stages of therapy, but his severe anxiety returned. He was then prescribed venlafaxine, 37.5 mg/d titrated to 225 mg/d across 3 weeks. His anxiety symptoms again abated.

How could Mr A's and Mr. B's doctors have avoided their initial misdiagnoses?

Handwriting lines for the second question.

Dr. Benzick's observations

"Cultural paranoia" describes adaptive or healthy responses by African-Americans living in a society they perceive as racially prejudiced. Several researchers have studied this concept of protecting self-esteem by blaming an external source for negative events. Women who plausibly attribute unflattering feedback to prejudice exhibit higher self-esteem. A person who believes he or she is a target of discrimination identifies more strongly with his or her racial or ethnic group, leading to reduced depression, higher self-esteem, and improved psychological adjustment.

Perceived discrimination, however, can also elicit feelings of hopelessness and resignation when it leads to widespread bias against the alleged oppressing racial or ethnic group. The resulting sense of social exclusion has been linked to lower self-esteem and higher rates of anxiety and depression. Thus, the individual's environment and ability to develop relationships will determine whether "cultural paranoia" is "adaptive."

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Paranoia or prejudice? Distinguishing culturally sanctioned “paranoia” from “prejudice” can be difficult. “Prejudice” is defined as the negative evaluation of a group or individual based on group membership.¹⁰ “Paranoia” (using the DSM-IV definition of “paranoid ideation”) is a belief of less than delusional intensity “involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.”²

So while an individual may be prejudiced toward a group, cultural paranoia would exist only if other family members or acquaintances believe the other group is conspiring against them. Additionally, while prejudice tends to be ego-syntonic,¹¹ paranoia is more distressing because it produces heightened vigilance and possibly fear.

Both cases describe how a lack of cultural understanding between African-American patients and physicians of other ethnicities or races can lead to misdiagnosis of psychosis.¹² They also illustrate that while prejudice may be tightly focused (eg, hatred of anyone from a specific racial or ethnic group), paranoid ideation can be generalized. For example, Mr. A believed that his wife, an African-American, conspired with his white supervisors against him.

Mr. A's and Mr. B's depressive and anxiety symptoms unmasked longstanding, deeply rooted

A clinician's approach to therapy can help prevent misunderstandings and misdiagnosis when treating patients from a different race or ethnic group. Consider the patient's history, attitudes toward race, and possible past trauma before labeling the patient as psychotic.

BottomLine

 **Related resources**

- ▶ Lu FG. Annotated bibliography on cultural psychiatry and related topics-June 2003. Available at: <http://www.admsep.org/culture.html>. Accessed July 18, 2003.
- ▶ Forsell Y, Henderson S. Epidemiology of paranoid disorders in an elderly population. *Br J Psychiatry* 1998; 172:429-32.

DRUG BRAND NAMES

Fluoxetine • Prozac	Paroxetine • Paxil
Olanzapine • Zyprexa	Venlafaxine • Effexor
Nortriptyline • Aventyl, Pamelor	

DISCLOSURE

Dr. Benzick reports no financial relationship with any company whose products are mentioned in this article, or with manufacturers of competing products.

beliefs. Both patients' neurovegetative symptoms responded to medication and brief psychotherapy, and both returned to prior levels of functioning. The underlying mistrust remained, however.

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