Building a bridge: A case report on communicating mental-health diagnoses to patients of a culturally and linguistically diverse background

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Abstract
Objective: This paper is based on a case report, describing a protocol to help practitioners communicate mental-health diagnosis to patients from culturally and linguistically diverse (CALD) backgrounds. The protocol was presented by integrating the DSM-5 Cultural Formulation Interview (CFI) and the SPIKES protocol for communicating the diagnosis of cancer, yielding a modified CFI-SPIKES protocol (i.e. S, Support; P, Perception using CFI; I, Invitation; K, Knowledge; E, Emotions). The protocol was demonstrated using a case report with a patient of a Middle-Eastern background experiencing generalised anxiety disorder.

Conclusions: The CFI-SPIKES protocol for communicating mental-health diagnosis allows for a collaborative process, whereby the CALD patient and practitioner can address the stigma associated with communicating a mental-health diagnosis, ensuring patient engagement and informed shared decision making.

Keywords: diagnosis, culture, mental health, protocol, communication

Since the 1970s, culturally and linguistically diverse (CALD) migrant populations in Australia have been increasing. In 2013, 18% of the total population was from a CALD background.1 In Australia, the term ‘CALD’ is a ‘broad and inclusive descriptor for [immigrant and refugee] communities with diverse language, ethnicity, nationality, dress, traditions, food, societal structures, art and religion characteristics’.2 Emerging evidence suggests access to mental-health services by some specific CALD groups in Australia is increasing.3 A recent systematic review suggests many practitioners do not communicate mental-health diagnoses with CALD populations (22%) for fear of reinforcing stigma.4 Another review found five key predictors of culture-related medical communication problems that may reinforce stigma.5 They include cultural differences in explanatory models, cultural values, preferences for doctor–patient relationships, racism/perceptual biases and linguistic barriers. The aim of this case report was to present to practitioners a protocol that address these predictors and associated stigma when communicating mental-health diagnosis to CALD populations.

Patient engagement and informed decision making are critical in health and mental-health communication, irrespective of ethnicity.6-8 Studies have found that providing good information and supporting patients to generate a list of questions regarding their health care address some of these barriers to communication, increasing patient engagement levels across some CALD populations.2,9 In addition, a review of the literature on communicating mental-health diagnosis found that there is no empirically tested model for communicating
mental-health diagnosis; stigma needs to be addressed with those patients who have a reaction of shame to receiving a mental-health diagnosis\textsuperscript{10-12}; and the SPIKES protocol for ‘breaking bad news’ borrowed from oncology as the most frequently utilised for communicating mental-health diagnosis.

SPIKES is a six-step protocol that provides an initial framework of providing information to the patient.\textsuperscript{13,14} Step 1 is the setting up (S) of the interview, that is, building therapeutic alliance. Step 2 is the assessment of the patients’ perception (P) of their problem. Step 3 involves obtaining the patient’s invitation (I) about wanting a diagnosis. Step 4 involves giving the patient knowledge (K) about the diagnosis in a non-technical way. Step 5 includes addressing the patient’s emotional (E) reactions to the diagnosis via empathy. Step 6 provides the patient a summary (S) about the diagnosis and treatment plan. The two main critiques of the SPIKES protocol are that it addresses stigma poorly\textsuperscript{14} and assumes that receiving a mental-health diagnosis is bad news.

Consequently, an adapted SPIKES protocol may be required to address the stigma concerns of the patient better and to challenge the ‘breaking bad news’ assumption of some practitioners.\textsuperscript{14} One structured approach that may help practitioners address a patient’s stigma associated with communicating a mental-illness diagnosis, irrespective of ethnicity,\textsuperscript{15} is the DSM-5’s Cultural Formulation Interview (CFI).\textsuperscript{16}

The CFI’s seven sections provide a structured interview assessing the following:

1. Cultural definition of the problem.
2. Cultural perceptions of the cause of their mental illness.
3. Stressors and supports that make the problem worse or better.
4. Role of cultural identity and how it makes the problem better or worse.

The CFI is applied at step 2 (i.e. P; Perception) in the SPIKES protocol to obtain a thorough understanding of the patient’s stigma associated with their mental illness. The CFI allows the practitioner to maximise patient engagement by assessing the patient’s stigma associated with a diagnosis across a range of dimensions, including their explanatory model (sections 1 and 2), cultural values (section 4), perceptual biases (sections 1, 2, 4, 5 and 6), communication preferences in doctor–patient relationship (sections 5 and 7) and linguistic barriers (section 6). This step (CFI) prepares the practitioner to address the possibility of the patient declining wanting a diagnosis due to stigma by partially disclosing (i.e. description of symptoms without diagnostic label) the diagnosis to avoid placing further stress on the patient.\textsuperscript{17}

The CFI and SPIKES protocol will be applied to the patient in the following case report to demonstrate the use of the protocol.\textsuperscript{2}

Case report

The patient is a separated 50-year-old male from the Middle East, referred by a religious leader and presented for the first time to a psychologist in private practice. The psychologist uses the CFI routinely but not the SPIKES protocol. In the ‘setting up’ (S) of the interview, the patient requested his wife and the religious leader be involved in the treatment. In assessing the perception of the problem (P), CFI was used. Patient reported that he worried excessively about finances, parents, siblings, children and his wife having an extramarital affair. He reported that his wife and children were not listening to him and that would make him very angry, leading to his wife placing an Apprehended Violence Order and separation. Second, his explanatory model of his problem attributed his anger to spiritual causes, stating: ‘I feel it is the devil that makes me do bad things, when the pressure increases, the devil can take over you’. Third, he indicated that his anger was worse when his wife spent too much time out of the house and did not attend to her household duties. Fourth, he reported the cultural imperative of saving face was important (i.e. shame of marital discord), leading to the avoidance of family functions. Fifth, he disclosed previous marriage counselling with his religious leader. He reported a family member receiving a diagnosis of bipolar disorder and feared receiving the same diagnosis. Sixth, he reported the barriers of cost, lack of time and his cultural beliefs associated with taking medication (i.e. it meant that he was mad and crazy). Seventh, he reported that he wanted to continue to see the psychologist, but financial and time restraints resulted in poor adherence to psychological treatment.

The patient agreed to invitation (I) and requested if the diagnosis could be explained to his wife and religious leader. The patient was provided with a visual presentation of the formulation showing the relationship between his diagnosis of generalised anxiety disorder (GAD), anger and his marital relationship. Symptoms of GAD were described by the psychologist in a non-technical way using the language of the patient (i.e. worrying leads to an increase in pressure needing to be released as anger’). In addition, information was given about how medication may help him feel calmer to ‘reduce the pressure’. He was asked to consider visiting his GP to discuss medication. At his request, a consultation with wife and religious leader discussed the formulation, including his diagnosis, medication and other treatment options (K).

The patient reported feelings of shame about taking medication and feared being stigmatised by his family or
community if they found out that he was taking medication. Here, his fears were normalised and confidentiality reassured. Finally, he was provided with a summary of the formulation and treatment options (step 6). In later consultations, the patient reported that he had visited the GP and commenced medication because: (a) he believed the medication would help, (b) his wife was very supportive and (c) he hoped it would help him be reunited with his family. The wife and religious leader were satisfied with the service and encouraged the patient to continue psychological treatment. Moreover, the patient reported feeling supported and continued to seek psychological treatment.

Discussion and conclusion

This case report highlights the importance of combining the SPIKES protocol and the DSM-5 CFI (CFI-SPIKES) to target explicitly stigma that may arise when communicating mental-health diagnosis. The CFI section (P) used in the present case report revealed that the patient’s stigma was associated with his explanatory model of mental illness (i.e. spiritual possession), the fear of receiving a diagnosis of bipolar disorder and taking medication. Despite the stigma, the patient agreed to full disclosure of diagnosis of GAD for himself, his wife and the religious leader (I). In addition, further exploration of his emotional reactions to the diagnosis and treatment occurred, indicating that the step E of the SPIKES protocol may need to be revisited. Thus, in the adapted CFI-SPIKES protocol, the P, I and E parts of the adapted protocol provide opportunities for the practitioner to address the elicited stigmatised patients’ response and improve patient engagement. Moreover, it offers a possible pan-human approach of communicating mental-health diagnoses that moves beyond ethnicity, including other diversity factors such as age, gender, class, sexual orientation, religion and so on. A possible challenge of using the protocol include time constraints arising in the setting up of subsequent consultations involving family and community members requested by the patient.

The limitations of the paper include the construct of CALD and the untested CFI-SPIKES protocol. The construct CALD runs the risk of presenting CALD populations as a homogenous group, which is not the case. Nevertheless, the CFI-SPIKES protocol provides a tailored approach that accounts for the differences within and across CALD populations and beyond. Future research is needed to evaluate the efficacy of the CFI-SPIKES protocol across diverse groups. The lead author is currently using the adapted protocol to train psychologists working for a telephone support service to improve communicating mental-health diagnoses.

In conclusion, the CFI-SPIKES protocol has the potential to build a bridge between the patient’s cultural explanatory model and treatment preferences and the mental-health practitioner by addressing stigma and increasing patient engagement and informed decision making about treatment.

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Note

a. Patient consent to publish case report was received, and identifiable information was altered.

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