

Cultural Issues in Emergency Psychiatry: *Focus on Muslim Patients*

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ABSTRACT

The emergency room (ER) psychiatrist confronts an increasingly diverse patient population that presents complex challenges to diagnosis and treatment in this acute setting. Such challenges include difficulties involving language barriers, interpretations of behaviors, prayer and fasting rituals, gender roles, attitudes about mental health, family issues, and other cultural issues. The Muslim patient presents the ER psychiatrist with a unique set of these complexities and challenges. The Muslim population in the United States is growing rapidly and comprises a very diverse array of cultures, racial backgrounds, languages, and Islamic traditions. The current literature is deficient in addressing this problem. This article summarizes the available relevant demographic and cultural data on the Muslim population in the US, including Islamic beliefs and practices within that population; outlines the importance of cultural competency within the psychiatric ER setting in avoiding adverse outcomes and improving care; presents two clinical vignettes to illustrate culturally relevant points in patient care; and discusses a set of guidelines and principals intended to promote cultural competency in meeting the needs of the Muslim patient in the psychiatric ER.

INTRODUCTION

As the United States population becomes more ethnically diverse, it is to be expected that more patients of diverse origin will be presenting to treatment centers. According to the

FOCUS POINTS

- The United States Muslim population is growing rapidly.
- Muslims in the US come from a diverse array of cultures and racial backgrounds, speak different languages, and adhere to different sects within Islam.
- Clinicians who provide care to Muslim patients should learn about locally predominant Muslims and their customs and seek to enhance their cultural competence.
- To avoid adverse outcomes and improve patient care, it is critical that clinicians recognize, understand, and respond to the unique cultural needs of Muslim patients in the setting of the psychiatric emergency room.

2008 US Census, minorities who are now ~33% of the US population are expected to become the majority in 2042. By 2023 minorities will account for >50% of all children.¹ Ethnic minorities face many challenges in obtaining appropriate care due to language barriers, deficits in cultural competence of clinicians, underrepresentation of clinicians from ethnic minorities, and a healthcare system that is not set up to address the cultural needs of diverse populations.²

Emergency psychiatrists routinely encounter patients from diverse cultures with various customs, practices, and beliefs. Cultural awareness, ie, the ability of the psychiatrist to understand and respond to the unique cultural needs brought by patients to the encounter, is a critical tool. The psychiatrist needs to consider the patient's culture as it relates to the presenting symptoms and history, and to help formulate a treatment plan that is mutually agreed upon by the physician, patient, and, very often, patient's family. The American College of Emergency Physicians has recently issued a policy statement that cultural

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awareness should be an essential element in training and in the provision of safe, quality care in the emergency department.³ However, there are no current statements or guidelines issued by the American Association of Emergency Psychiatry.

The challenge of cultural awareness is more acute in the emergency setting precisely because of the need for rapid assessment, diagnosis, and treatment. Ethnic minority patients are especially in need of effective mental health treatment as they typically have less access to care, are frequently misdiagnosed (depression and psychosis often go undiagnosed),² are at high risk of child abuse, and may be particularly vulnerable due to the effects of poverty, refugee status, and the stress of acculturation.⁴

This article focuses on Muslim patients and cultural issues that may be encountered when evaluating and treating them in the emergency room setting. The authors present two clinical vignettes to illustrate culturally relevant points in patient care. They briefly describe Muslims in the US in terms of demographics, religious beliefs, practices, and relevance to psychiatry. Finally, the authors discuss a set of guidelines and principals intended to promote cultural competency in meeting the needs of the Muslim patient in the psychiatric emergency room.

CASE VIGNETTES

Case 1: Patient-Doctor Relationship, Dress Code, and Modesty Issues

A 19-year-old Somali-origin, English-speaking woman was brought to the emergency department by her family because of recurring anxiety attacks. In the preceding 4 days the family had taken her to different emergency departments twice due to shortness of breath, palpitations, agitation, and fear of dying. On both occasions she was medically cleared and sent home with a plan to follow up with her physician. On her third presentation, the patient was triaged directly to the psychiatric emergency service for evaluation. She was agitated, restless, moaning, with increased respiratory rate but otherwise normal vital signs, and cooperative with the routine safety check. She was dressed in traditional Somali clothes: floor-length gray dress, long sleeves, and scarf (“hijab”) covering her head. She was accompanied by her older sister and non-English speaking mother who was interviewed via a Somali interpreter. The family reported she had no prior psychiatric, substance use, or significant medical history.

As the male physician entered the room, the patient jumped from the gurney and began screaming and pounding on the wall. Her sister tried to calm her with no success. The female nurse tried to de-escalate the situation but the patient pushed her to the floor. A behavioral code was called, and after security officers arrived, the patient was placed in physical restraints. Throughout the restraint procedure she remained agitated and her scarf

slipped from her head. At that point she became combative, non-directable, and received intramuscular lorazepam 1 mg to calm her. Subsequently, psychiatric assessment was completed and the patient was discharged home with family, short-term medication treatment, and psychiatric follow up.

Case 2: Dehydration Due to a Religious Practice

A 32-year-old Caucasian, non-English speaking man was brought to the emergency department by his family because for several days he had been agitated, sleeping poorly, talking to himself, and making statements that people from work were after him and wanted to kill him. The patient presented in early July when outside temperature was >95° F, and at triage, his blood pressure was 112/72 mmHg, pulse 102 beats per minute (BPM), respiratory rate 18, and body temperature 37° C. He was triaged to the psychiatric emergency service without a medical work-up. He had no prior psychiatric, substance use, or significant medical history. Married with two small children, he was a refugee from Bosnia who worked swing shift in a local factory.

Interviewed via a Bosnian interpreter, the patient was oriented to self, place and time, but distractible and unable to focus or sustain attention. He endorsed persecutory delusions and was visibly suspicious, checking behind the door and under the bed. He was intermittently cooperative with the interview, and initially refused a blood draw and urine for laboratory tests. When the nurse brought him water, he declined, became acutely agitated, and pushed her against the wall. He was placed in physical restraints for safety. He was ultimately admitted to the hospital on an involuntary basis.

THE MUSLIM POPULATION IN THE US

Demographics

The US Census does not collect information on religion and reliable estimates of the US Muslim population are limited. The best scientific estimates of the Muslim population in the US place the total number at 2.4–2.8 million and the number of adult Muslims at 1.4–1.5 million.⁵⁻⁷ Non-scientific estimates of the US Muslim population as high as 7 million⁸ have been made. However, the issue remains controversial.⁹ Of adult US Muslims, ~65% were born elsewhere, and 39% arrived in the US since 1990. As many as 72% of Muslim Americans are foreign born or have roots abroad in at least 68 countries, with no single nation accounting for >12% of these immigrants.⁶

American Muslim traditions, practices, languages, and beliefs are correspondingly diverse. Approximately 37% emigrated from Arabic-speaking countries in the Middle East and North Africa; 27% from South Asia, including Pakistan, India, Bangladesh,

and Afghanistan; 8% from European countries; and 6% from other parts of Africa.⁶ Thirty-five percent of American Muslims are native born, and African-American converts to Islam constitute 20% of the total US Muslim population.⁶ The overall US Muslim population is reported to be fast-growing but reliable statistics on this growth are nonexistent. The American Religious Identification Survey estimated the US Muslim population to have grown by 156% between 1990–2008.⁵ Immigration from Islamic countries, however, has grown rapidly since 2005.¹⁰ Table 1 summarizes these statistics.

ISLAMIC RELIGIOUS BELIEFS AND COPING

There are no reliable epidemiologic surveys of the prevalence and incidence rates of major mental disorders among the US Muslim population, but there is no reason to believe these rates differ significantly from the population at large. When people become ill, mentally or physically, they and their family will often rely on religious beliefs and practices to cope with stress, retain a sense of control, maintain hope, and preserve a sense of meaning and purpose in life. This involvement with religion can promote, in the face of illness, movement towards psychological growth and resilience rather than despair and defeat.¹¹

For Muslims, reliance on religious beliefs and practices as a means of coping with illness can assume a particular prominence: a recent survey of religious and non-religious coping practices amongst different ethnic groups in the United

TABLE 1
THE MUSLIM POPULATION IN THE US^{5,6}

No Census data on religion
Estimated US Muslim population: 2.4–2.8 million
1.4 million adults (0.6% of US population)
65% foreign born, 35% native born
39% arrived in the US since 1990
Diverse
<ul style="list-style-type: none"> • Roots in 68 countries; no single one accounts for >12% • 37% emigrated from Arabic-speaking countries in the Middle East and North Africa • 27% from South Asia, including Pakistan, Afghanistan, India, Bangladesh • 8% from European countries • 20% are African-American converts to Islam
Fast-growing

US=United States.

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Kingdom, for example, found that cultural or spiritual coping practices are often indistinguishable from religious coping among Muslims.¹² According to a recent Pew Foundation survey,⁶ Muslim-Americans assign considerable importance to Islamic religious practices. The practice of fasting during Ramadan, for example, is “very important” to 77%, and 72% say their religion is “very important” in their life. These numbers are very similar to figures for Americans in general, regardless of their particular faith.⁶

Abu Raiya and colleagues¹³ developed a reliable 60-item Psychological Measure of Islamic Religiousness (PMIR) that assesses Islamic identification, beliefs, ethics, religious duty, coping, and other domains of Islam relevant to physical and mental health. In a sample of 64 Muslims in the US and Israel and an international sample of 340 Muslims findings from the PMIR indicated that Islam was central to the well-being of these individuals. This measure is a new tool for both clinical practice and research in an underdeveloped area; a shortened form of it may be useful to assess Islamic religiousness and coping in the emergency room setting. Amer and colleagues¹⁴ have also tested a religious coping scale applicable to Christian and Muslim Arabs. Arab Muslim attitudes toward seeking mental health services have been shown to be affected by cultural and traditional beliefs about mental health, perceived societal stigma, knowledge and familiarity with available services, and the use by patients and families of informal indigenous resources.¹⁵ In addition, Muslims in the US and elsewhere often seek guidance for mental health issues from imams.¹⁶ Muslim clerics can help bridge the gap between Islamic intervention and modern, Westernized approaches to mental health. Readily-available spiritual consultation by Muslim clerics in the emergency room can therefore be extremely useful. Positive religious coping has been shown to be positively related to optimism and negative religious coping to be negatively associated with hope in Muslim war refugees.¹⁷

Suicide is expressly condemned in the Qu’ran. Religious countries have lower suicide rates than secular ones¹⁸ and Islamic countries throughout the world appear to have lower suicide rates compared to other developed or developing countries.^{19–21} However, reported rates vary greatly, under-reporting biases may exaggerate these impressions,²² and whether these trends have had any carryover to suicide rates among Muslim immigrants to the US is unknown.

PSYCHIATRY AND ISLAMIC AND MUSLIM CULTURAL INFLUENCES

Several cultural characteristics can influence how Muslim patients and their families interact with emergency room providers (Table 2).

Often, the value of an individual's independence is balanced or outweighed by his or her interdependence within the family unit and the community.^{23,24} The decision to seek professional medical help is often made by the family as a collective. Admission to a hospital is commonly a decision made jointly by the doctor, patient, and accompanying family member(s). These may be parents, siblings, or extended relatives. Their support for the patient, by demonstrating interest in the patient's well-being and need for treatment, can be crucial. Their experience in their country of origin, moreover, can make the US civil procedures of involuntary commitment difficult to understand. For patients in traditional societies in Qatar and Kuwait, for example, involuntarily hospitalization is often arranged primarily by securing the verbal agreement of relatives alone; that is, collaboration with patients' families in these societies has obviated the felt need for formal legal procedures and safeguards.²³ In this process, the rights of the family are weighed along with the rights of the patient, with surrounding issues of stigma and shame brought on families being brought into consideration.²³

El-Islam²³ has characterized several issues that can complicate the doctor's encounter with these patients in the emergency room. Psychiatric patients from Muslim communities can expect the psychiatrist to "remove" their suffering without active work on the patients' part. Western-trained psychiatrists might misinterpret such behavior as uncooperativeness or passivity. Family members of such patients can help as "co-therapists."²³ Patients and relatives may also be less likely to disclose information about mental illness, sexual activities, abuse, and unlawful acts within the family because of the stigma and social shame that result. Culturally shared beliefs can be difficult to distinguish from delusions. For example, commonly-held ideas about the devil tempting human beings to wrongful ideas, feeling, and actions can be mistaken for first-rank symptoms of thought control or insertion, or passivity delusions. Obsessive

ruminations can be interpreted by patients as satanic temptations and often involve antireligious rather than contamination themes.^{23,24} Conversion and somatization disorders tend to occur more frequently among Muslim women, as physical symptoms of conversion are more socially acceptable than direct verbal expression of emotional distress and protest.²³

In the institution where the authors of this article work, clinicians often encounter Somali-Muslim refugees. These patients have high rates of posttraumatic stress disorder, yet they tend to avoid mental health treatment due to the cultural stigma of mental illness as well as a fear of harsh treatment and being institutionalized.²⁵

Gender roles is another challenging area. In Muslim culture, gender roles and responsibilities are more strictly defined than in contemporary North American culture, and cross-gender interactions can be more awkward and stressful. The dress code in Muslim culture is very strict: Islam traditionally commands a woman to cover herself completely when outside of her home. As illustrated in Case #1, gender-discordant interactions may at times cause severe discomfort and psychological harm.²⁶ The presence of a female clinician is more acceptable and appealing to many Muslim woman.²⁷

CASE RESOLUTIONS

The case of the young Somali-Muslim patient illustrates the need for a patient-centered approach that includes an exploration of the patient's beliefs and practices as well as understanding of specific Somali cultural taboos, mores, religion-based ethics, and cultural accommodations. Mental illness remains highly stigmatized in Somali culture. For Somalis, the concept of mental health has traditionally been reduced to the categories of "sanity" and "insanity."²⁸ The psychiatric concepts of mood and anxiety disorders in particular are unfamiliar to the Somali explanatory model of mental illness. Mood and anxiety disturbances are addressed rather by family support, religiously based interventions, and indigenous herbal remedies.²⁹ Those suffering mood disturbance avoid seeking treatment from a doctor or institution for fear of being labeled "insane" and shaming their family.³⁰

An understanding of this patient's cultural background may have enabled the staff to more quickly and competently differentiate the reasons for the patient's agitation and restlessness. Facing a psychiatric evaluation may have caused this young Somali woman to fear that she was going to be labeled "insane". An exploration of the patient's beliefs about her illness and reassurance may have allayed some of her fears. Had the patient been forewarned that she was to be evaluated by a male doctor, she may not have reacted so dramatically when he entered the room. Also, the fact that her head scarf slipped from her head was likely highly distressing for this patient. The acknowledgement of, respect for, and cooperation with cultural beliefs may have led to a more favorable healthcare encounter for this patient.

TABLE 2

CULTURAL AND EXPERIENTIAL CHARACTERISTICS INFLUENCING THE ER ENCOUNTER WITH THE MUSLIM PATIENT

Autonomy vs. interdependence within the family and community
Attitudes about stigma, social shame, and disclosing information
Experiences and attitudes about hospitals and civil commitment
Commonly held religious beliefs
Somatization
Posttraumatic syndromes
Gender roles and dress codes
Religious customs (eg, Ramadan fasting)

ER=emergency room.

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In the case of the Bosnian-Muslim man with agitation and paranoia, medical reasons for his condition were overlooked. This patient had been fasting during the holy month of Ramadan, the Islamic religious holiday. Throughout this month practicing Muslims refrain from drinking, eating, smoking, and sexual activity from dawn to dusk. The lunar month of Ramadan occurs at different times of the year, and in northern latitudes during the summer months fasting periods can be significantly prolonged, between 16–22 hours per day. Practicing Muslims pray five times a day: “Fajr” (before dawn), “Zhur” (noon), “Asr” (mid-afternoon), “Magreib” (after sunset), and “Isha” (before bedtime). During the month of Ramadan, special night prayers (“Taraweeh”) are conducted after Isha. The prayer includes recitating verses from the Qur’an and a series of bowing and prostrating to God while facing in the direction of Mecca.

For this patient, Ramadan fasting in the summer months with high temperature and extended daylight made it challenging to keep hydrated and withstand factory swing shift work. The patient would stay without food or fluids often until the end of his shift. Over the week prior to developing symptoms he had become significantly dehydrated and on presentation he exhibited mild tachycardia. Urinalysis showed 2+ ketones (40–79 mg/dl) and high specific gravity (1.040 g/ml), indicative of catabolism and dehydration. Blood pressure and pulse were re-measured and found to be orthostatic (sitting: 108/72 mmHg, 102 BPM; standing: 90/68 mmHg, 125 BPM). Laboratory tests indicated elevated hematocrit (50%); increased sodium (150 mEq/l), creatinine (2.0 mg/dl), and blood urea nitrogen (31 mg/dl); and high serum osmolality (340 mOsm/kg).

Because the patient refused fluids by mouth (it was in the middle of the daily fasting period) and continued to be agitated, confused, and paranoid, he was admitted involuntarily to the psychiatric department as gravely disabled and a danger to others. He received intravenous hydration on the inpatient unit and within 48 hours all medical and psychiatric symptoms resolved.

Psychiatric hospitalization may have been avoided had the clinicians, in the early stages of the evaluation, inquired and known of this patient’s religious practice and thus have had suspicion for dehydration as an etiology of his symptoms. The situation may also have been influenced if the clinician had known that the patient was not allowed to take fluids during the day, and delayed re-hydration until the permissible hours. An additional consideration about this patient is that his agitation in the PES might have been related to the interruption of his daily prayers.

While it has been reported that practicing Muslims suffer from intermittent dehydration during the daylight hours of Ramadan fasting, a recent review³¹ reported no serious detrimental effects on health of the negative water balance. However, there is no data on the effects of dehydration in the emergency room context. Data on the impact of Ramadan on emergency department utilization, particularly in the US, are scant. One British study³² reported an increased number of Muslims who

attended the emergency department during the month of Ramadan compared to similar time periods before and after Ramadan. However, a recent study³³ in Turkey found that clinical features of patients admitted to the emergency department, and the number of emergency department admissions during Ramadan and 1 month after, did not differ significantly. Another study³⁴ in Turkey reported higher admission rates in the emergency department for hypertension and uncomplicated headache but did not find any differences in frequencies for ischemic cardiovascular diseases or diabetes-related visits during Ramadan comparing to non-Ramadan months.

DISCUSSION

Because of the unique nature of the emergency room setting, the physician must establish rapport and reliable communication in a brief contact that may occur under considerable time pressure. Obtaining relevant information, quickly reaching impressions regarding the patient’s underlying condition, and making diagnostic and treatment decisions are always challenging. The authors of this article describe here the unique set of challenges posed by the encounter with the Muslim patient in this setting.

Muslims in the US come from a diverse array of cultures and racial backgrounds, speak different languages, and adhere to different sects within Islam. Their degree of religious conservatism also varies, as reflected in their choices of clothing; eating and drinking habits; and many traditions, customs, and beliefs.^{35,36} There is a paucity of literature highlighting healthcare delivery specifically to Muslim patients in Western countries. Issues surrounding halal food (foods that are allowed under dietary guidelines defined in the Qur’an, and the prohibition of alcohol), fasting during Ramadan, intergender physician-patient aspects of care, the wearing of the hijab, segregation of genders on wards, having an area for prayer available, and the role of family, often remain elusive to many within Western healthcare systems.^{23,36-41}

Recognition of these cultural differences is a necessary step in developing strategies to improve care. Training in cultural awareness is essential. Hammoud and colleagues⁴² have proposed two levels of cultural competence. The first level refers to the basic understanding of certain beliefs and customs that have potential to influence the life of an individual within a certain culture. The second level pertains to the exploration of individual and unique issues that are related to health and illness.

In accordance with the Accreditation Council for Graduate Medical Education standards, psychiatry residents are expected to develop skills to address culturally diverse patient populations. Residents and other providers should be taught that patient-centered care requires cultural sensitivity at an individual, group practice, and institutional level. At the individual level, good communication, trust, and relation-

ship building are essential. When providers do not speak the patient's language, having an experienced interpreter whom the patient trusts should be a priority. This is not always achievable if interpretation services are limited, but is the ideal to strive for in any institution. Important aspects of non-verbal communication include showing patience, kindness, and a genuine interest in understanding the patient's presenting problems as well as the patient's culture and how this may be influencing the presentation. Trust is built when a patient feels valued and understood, in an atmosphere without prejudice. Through good communication and trust, an effective doctor-patient relationship is built. Education through focused didactics, seminars and "on the job" modeling is essential for trainees and staff. Betancourt and colleagues⁴³ maintain that physicians need a practical set of tools and skills that will enable them to provide quality care to patients everywhere, from anywhere. They propose teaching a patient based approach to cross-cultural care and communication consisting of first, assessing the core cross-cultural issues; second, exploring the meaning of the illness; third, determining the social context; and fourth, engaging in negotiation. Clinicians who provide care to Muslim patients should at a minimum learn more about locally predominant Muslims and their customs.

Padela and Punekar⁴⁴ have proposed strategies, at group practice and institutional levels, to increase cultural awareness and reduce disparities in emergency care. Their strategies include reducing provider bias and increasing provider cultural awareness, clinically accommodating patients, and promoting workforce diversity. These are potential approaches that may be taken to help improve awareness and care of Muslim patients in the emergency department setting.

Sociocultural differences between patient and provider may result in miscommunication, distrust, poor treatment adherence, and worse outcome. Improperly trained clinicians may resort to stereotyping and even biased or discriminatory treatment of patients based on race, ethnicity, culture, language proficiency, or social status. The encounter with the Muslim patient in the Western world is especially fraught with potential misunderstandings. For example, Muslim women who wear the "hijab" are particularly vulnerable to stereotyping. Stereotyping occurs more frequently in times of stress, time constraints, and multitasking, making the emergency room a particularly problematic area in this respect.^{45,46} The term "dynamic sizing" has been suggested as a means to gain active control of the tendency to use stereotypes.^{47,48} This requires knowledge of when to generalize and be inclusive, and conversely when to individualize and be exclusive. It has been argued that a diverse healthcare workforce may also promote tolerance and cultural awareness through increased peer interactions with others from diverse backgrounds. This may lead to greater advocacy for internal changes to improve the

care for populations in need. If patients and clinicians share common values, including language, this can promote greater participatory decision making and trust.⁴⁹

In addition, some institutions incorporate cultural consultation services and cultural case mediators to provide a further level of cultural awareness to patient care. For example, in the authors' institution, an in-house Somali cultural liaison is available. A simple measure that can be implemented at the institutional level is the posting of calendars that include holidays such as Ramadan, with reminders of the fasting issues patients bring.

CONCLUSION

Cultural factors are of fundamental and increasing importance to healthcare delivery and health-related behavior; these factors can have a profound effect on the expression of psychiatric illness. Despite, and in fact because of, the pressures and stress of an emergency room, improved cultural awareness in this setting promotes efficient, higher quality care. This article emphasizes the expanding need for clinicians to recognize, understand, and respond to the particular needs of Muslim patients in the setting of the psychiatric emergency room. These skills can also generalize or transfer to the approach to other populations: if clinicians strive to build the skills necessary to enhance cross-cultural expertise with regard to Muslim patients, then healthcare outcomes and quality of care for patients from other cultural backgrounds may also be enhanced. **PP**

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