Cultural aspects of telepsychiatry

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Summary
Telepsychiatry may involve working with clinicians, patients and systems of care that are both geographically and culturally distinct. In this context, culturally appropriate care is an important component of telepsychiatry. The outline for cultural formulation from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) provides general principles for addressing these issues. Two components of the outline are particularly relevant in telepsychiatry: (1) how the cultural background of patients (i.e. their cultural identity) influences their comfort with technology; and (2) the effect of cultural differences on the patient–provider relationship. Cultural differences between patient and provider are often highlighted in telepsychiatry by the patient and provider location (e.g. rural versus urban differences). Familiarity with the rural community and regular contact and feedback are important. Future research should examine the effect of telepsychiatry on patient–provider relationships, patient attitudes towards care and, most importantly, patient outcomes.

Introduction
Telemedicine, in the form of realtime videoconferencing, has the potential to address health disparities.1,2 This is especially true of psychiatric care, where the disparities are often substantial,3 and videoconferencing promises to improve access to high-quality psychiatric care, particularly for rural, remote and underserved populations.4,5 In this context, providing culturally appropriate care is important to treatment process and outcome. The provision of culturally appropriate care – health care that facilitates the development of a strong therapeutic relationship between clinicians and patients from different cultural backgrounds6,7 – is increasingly being emphasized in practice standards. The emerging literature, although largely descriptive, stresses the role of culturally appropriate care in addressing disparities.8 Culturally appropriate care is best ensured by training clinicians in key cultural competencies.

To our knowledge, no previous articles have addressed cultural appropriateness or cultural competency in telemedicine generally, or telepsychiatry specifically. The literature on telepsychiatry with diverse populations has been limited largely to descriptive studies and case reports of prisoners,9,10 children11 and minority groups.5,12,13 Cultural aspects of care usually occasion a brief comment at best. No systematic framework has been proposed to address cultural aspects of telepsychiatry care.

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) includes an outline for cultural formulation that provides a framework for understanding cultural issues in psychiatric treatment.14 The five core components of the outline urge the provider to account for:

1. the cultural background of the patient;
2. the cultural explanation of the patient’s illness;
3. the cultural aspects relating to a patient’s psychosocial environment;
4. the impact of cultural aspects on the patient–provider relationship;
5. the overall cultural formulation for the care.

Because of its inclusion in the widely utilized DSM-IV and our previous experience in using the outline to develop cultural formulations,12,13,16 we feel that it represents an important framework for considering cultural aspects of care, including telepsychiatry care.
Telepsychiatry at Denver

This paper draws on our clinical and administrative experience in providing telepsychiatry for five years. The work has concerned the American Indian and Alaska Native Programs (AIANP) at the University of Colorado at Denver and Health Sciences Center (UCDHSC) and the Veterans Administration (VA). The services include nine different telepsychiatry clinics serving five western states (Alaska, Colorado, Montana, South Dakota and Wyoming) with the psychiatry staff for all of these clinics based in Denver. Seven of the clinics serve rural locations and focus on child, adolescent, adult and geriatric populations. The telepsychiatry services include consultation with local providers, diagnostic assessment, medication management, case management, family meetings, individual psychotherapy and group psychotherapy.

These clinics have served more than 150 patients via telepsychiatry. There have been over 1500 patient contacts. Approximately 65% of the appointments were with Northern Plains American Indian veterans, 15% Caucasian veterans, 15% Hispanic veterans, with the remaining 5% representing a mix of Alaska Native Elders, Caucasian geriatric patients and Northern Plains American Indian children. The patients had a wide range of psychiatric diagnoses, including anxiety, mood and substance-use disorders. More detailed descriptions of several of these services can be found elsewhere.5,12,13

Cultural identity of the individual

The patient’s comfort with videoconferencing is critical to the success of telepsychiatry. In our experience, patients’ level of comfort with videoconferencing is related to their past experience with technologies such as videoconferencing, the Internet, computers and mobile phones. Exposure to technology seems to be related to age and education: younger patients and those with higher levels of education have had greater exposure to these technologies and are therefore likely to display greater comfort with telepsychiatry.

However, the relationship between exposure to technology and age and education is not always straightforward. For example, we have noted that a number of older American Indian veterans treated in the AIANP telepsychiatry service, despite reporting both a childhood and a recent history of very limited exposure to technology, demonstrated a high degree of comfort with telepsychiatry. These veterans attributed this comfort to their experience with sophisticated communication systems during military service. We have also observed some unusual reactions to the videoconferencing technology. For example, it was observed by local staff that a boy with Asperger’s syndrome seemed better able to communicate via telepsychiatry than in-person. The clinical team speculated that this patient’s interest in movies and technology, as well as physical distance from the psychiatrist, rendered telepsychiatry a more comfortable form of treatment for him.

Because of its critical importance to the success of telepsychiatry treatment, comfort with and exposure to videoconferencing and technology in general should be assessed and discussed with the patient at the initial visits. For patients with low exposure or little comfort, extra time should be taken to explain the videoconferencing system. In addition, several times during the initial session and at the end of the session the provider should elicit the patient’s level of comfort, and invite questions specifically about the technology. For these patients, in particular, the provider should engage in continuing dialogue in subsequent sessions about the patient’s comfort with the technology.

Cultural elements of the clinician–patient relationship

Given the change in clinical interaction inherent in moving from face-to-face to telemedicine, it is not surprising that telepsychiatry has important implications for the doctor–patient relationship, particularly in cross-cultural settings.

Verbal and non-verbal communication

Telepsychiatry affects the verbal and non-verbal communications between doctor and patient. Providers need to be familiar with the communication style of the patient population. They need to be able to assess how telepsychiatry may affect this style and to adapt their communication style as appropriate. For example, with some Northern Plains American Indian elders, it is considered discourteous to have too much direct eye contact. A provider needs to be careful not to misinterpret lack of eye contact in such a patient as a clinical sign (e.g. of depression). Some providers, accustomed to direct eye contact with patients, find it more difficult to establish direct eye contact while using telepsychiatry. This may be an advantage in working with populations who consider direct eye contact disrespectful, of course. Nonetheless, the provider should be sure that the image on the television monitor is appropriately framed (i.e. not zoomed in on the provider’s eyes). A more distant
framing encompassing the provider’s head, shoulders and upper torso diminishes the appearance of direct eye contact.

In a series of weekly groups run by the AIANP to treat Northern Plains American Indian veterans suffering from post-traumatic stress disorder (PTSD), verbal communication was modified. The treating psychiatrist found that he needed to be slightly more directive with the telepsychiatry groups than with groups led in person. This was partly due to the group facilitator being in the same room as the group members, which artificially focused the group members on the facilitator. By inviting specific group members to speak during sessions, the psychiatrist found he could facilitate group interaction. In addition, at the beginning and end of each group, every member was invited to speak. This process is reminiscent of the ‘talking circle’, a traditional method of communication found in many of the Northern Plains tribes.

Telepsychiatry providers need to adapt their communication styles to suit the patient and cultural group in question. This requires that providers understand the population of interest, as well as the communication styles of individual patients. Providers should seek frequent reassurance about the patient’s comfort with their style of communication, and be willing to experiment with different styles.

**Establishing trust and rapport**

The other major effect of telepsychiatry on the patient–provider relationship relates to establishing patients’ trust and rapport. Trust and rapport may be harder to achieve when working with patients via telemedicine because of the technology and communication issues discussed above. Several of our telepsychiatry services depend on a local clinician to assist in the development of trust and rapport between the patient and psychiatrist. For example, each of the telepsychiatry clinics that treat Northern Plains American Indian veterans employs a clinic outreach worker referred to as a tribal/telehealth outreach worker (TOW). The TOW is always both a member of the local tribe and a veteran, usually someone who is respected among the local tribal veterans. The TOW is responsible for running the clinics at the remote site, liaison with the local tribe, scheduling and clinic outreach for the patients. The trust and rapport already established between the TOW and the clinic’s patients helps the latter feel more comfortable during the initial visits with the psychiatrist. In addition, the status of the TOW in the local community of veterans lends credibility to the psychiatrist and, often, the positive feelings towards the TOW are transferred to the psychiatrist. Finally, the TOWs work closely with the psychiatrists and guide them regarding cultural and other local issues relevant to a particular patient’s treatment.

Other AIANP telepsychiatry services have used local physicians to facilitate the development of trust and rapport, in a manner akin to the TOWs. These physicians have more specialized knowledge of the community than the psychiatry staff in Denver and can guide the consultant through cultural issues. If the local provider already has a good relationship with the patient, his or her presence during the consultation facilitates the formation of rapport between the consultant and the patient. For example, prior to an evaluation in our child and adolescent telepsychiatry consultation service, the grandmother of one child initially stated ‘I just don’t feel comfortable talking to a box’. The local doctor’s presence during the evaluation and continued involvement in the case thereafter ensured that she did in fact listen to and follow our recommendations.

Clinical facilitators are expensive, especially in the case of physicians. However, they may not always be necessary to accomplish the treatment objectives. A series of telepsychiatry clinics has been providing weekly medication management to white and Hispanic veterans living in rural southern Colorado. In these clinics, there are no local clinical facilitators directly involved.

The term ‘transference’ in psychiatry is used to describe a patient’s feelings towards important figures that ‘transfer’ to the provider. By analogy, ‘system transference’ refers to feelings that a patient holds regarding a system of care. Positive or negative feelings towards the system may be transferred to a provider working within that system. As discussed above, previous positive experiences with the VA can greatly assist the psychiatrist (as a VA representative) in establishing rapport. The converse may also occur and can become an impediment to a working alliance. Consequently, we strongly recommend that providers enquire about a patient’s feelings, attitudes and past experiences with the organization that will deliver telepsychiatry. If negative, the provider should be straightforward in acknowledging the shortcomings of the system, demonstrating empathy with the patient. At the same time, the provider should avoid becoming overly critical of the organization, which could lead to further negative transference and impede the patients’ ability to work with the provider and system.

By its very nature, telepsychiatry generally involves interactions between multiple systems, each with its own culture. Interactions between these systems, and past experiences of the client with the systems, will affect the therapeutic relationship. For example, one
of the AIANP’s telepsychiatry clinics involves a partnership between five different organizations (university, federal and tribal). The difference in organizational cultures had to be understood by all parties, as the clinic was tailored to the needs of the patient population, not the organizations themselves. In extreme circumstances it may be necessary to create a ‘new’ organizational culture specific to the clinics. Thus the TOWs, who facilitate the development of a positive doctor–patient relationship, have also been instrumental in constructing a new organizational culture at our clinics that is distinct from the VA and other participating organizations.

Confidentiality

Some patients are concerned about confidentiality and feel reluctant to fully disclose information via videoconferencing. In our experience, patients who are particularly likely to have these concerns include those who work in security-related fields (e.g. law enforcement), those with negative system transference and those who exhibit paranoid symptoms. Educating all patients at the initial visit about confidentiality issues, and revisiting this matter at subsequent visits with patients who express concerns, often alleviates such fears. On the other hand, many patients seen by telepsychiatry feel more comfortable seeing a remote provider than a local provider, whom they are likely to encounter outside the therapeutic relationship in the small rural communities that they share. In addition, patients who struggle with establishing close interpersonal relationships because of their illness (e.g. PTSD, pervasive developmental disorders) often find it easier to express themselves remotely, at a distance from the provider.

Cultural differences due to location

Cultural differences between provider and patient may be heightened by telepsychiatry. By their nature, most telepsychiatry services originate in large urban centres where providers are located and treatment is delivered to remote rural sites. The cultural divide between provider and patient, as evinced by urban versus rural lifestyles, can be enormous. Providers raised, trained, living and practising in large urban centres often have a limited understanding of rural environments and of how these environments affect their patients’ lives, communication styles and world views. There may also be significant variability among rural communities. For example, a Northern Plains American Indian community in Montana is very different from a Hispanic farming community in south-west Colorado. Nevertheless, the members of these two communities may have more in common with each other than with residents of a large city such as Denver.

Periodic visits to these rural sites have improved our understanding of the local settings, the rural culture and the local issues that confront the patients. These visits also demonstrate to all those at the rural sites – patients, ancillary staff and the community – that the provider has interest and commitment to working with them.

Limitations

The information presented here has several limitations. First, our work is based on specific populations and settings that may limit the generalizability of our observations. Second, the information is based on clinical work and requires more rigorous validation. Third, our work involves English as the primary language of communication, and may not be relevant to the use of interpreters in telepsychiatry. The effect of language on clinical encounters and patient outcomes has been emphasized in the general medical literature, but there has been little work in telemedicine. Fourth, although the cultural formulation has been used in international case presentations, we do not know to what extent the model may be relevant to work internationally.

Conclusions

The DSM-IV outline for cultural formulation provides a useful framework for approaching cultural issues in face-to-face encounters with patients. Issues of particular importance to telepsychiatry include the cultural beliefs of the patient and the cultural aspects of the patient–provider relationship. Cultural differences between patient and provider are often highlighted in telepsychiatry by the patient and provider location (e.g. rural versus urban differences). Familiarity with the rural community, and regular contact and feedback are important. The clinician should consider the effect of telepsychiatry on patient–provider communication and the therapeutic relationship. The individual components of the cultural formulation are summarized in Table 1. We recommend that telepsychiatry providers anticipate and enquire about these issues. In providing culturally appropriate care, we suggest that providers:

- enquire about the patient’s level of comfort with technology, educate the patient about technology, and continue to monitor the patient’s level of comfort during treatment;
Table 1 Cultural aspects of telepsychiatry in the cultural formulation

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<thead>
<tr>
<th>DSM-IV cultural formulation</th>
<th>Cultural aspects of telepsychiatry</th>
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<tr>
<td>Cultural identity of the individual</td>
<td>Previous exposure to technology. Impact of setting (‘rural’ culture) on patient’s cultural identity</td>
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<td>Note the individual’s ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use and preferences (including multilingualism)</td>
<td>‘System transference’ and the need to adapt systems of care to patient preferences. How the setting contributes to the patient’s explanation of illness</td>
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<tr>
<td>Cultural explanations of the individual’s illness</td>
<td>Impact of the setting on the patient’s psychosocial environment and functioning. Effect of systems of care on the patient’s approach to treatment</td>
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<td>The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g. ‘nerves’, possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual’s symptoms in relation to norms of the cultural reference group, any local illness category used by the individual’s family and community to identify the condition. The perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experience with professional and popular sources of care</td>
<td>Extent to which telepsychiatry alters patient–provider communication and what modifications are needed to communicate effectively over videoconferencing</td>
</tr>
<tr>
<td>Cultural factors related to the psychosocial environment and levels of functioning</td>
<td>How telepsychiatry influences both positively and negatively patient trust and rapport, including patient attitudes and beliefs about confidentiality</td>
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<td>Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental and informational support</td>
<td>Effect of differing systems of care between patient and provider’s location on treatment</td>
</tr>
<tr>
<td>Cultural elements of the relationship between the individual and the clinician</td>
<td>The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care</td>
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<td>Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g. difficulty in communicating in the individual’s first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behaviour is normative or pathological)</td>
<td>Overall cultural assessment for diagnosis and care</td>
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- become familiar with local communication styles and modify the communication style used in telepsychiatry, as appropriate;
- consider the use of clinical facilitators at remote sites;
- understand the possibility of ‘system transference’;
- assess the patient’s understanding and feelings towards confidentiality and the implications of telepsychiatry for their confidentiality;
- understand the effect of the patient setting on patient–provider communication;
- visit the remote site to become familiar with the community and the effect of telepsychiatry on the community environment and patients.

Future research should examine the effect of telepsychiatry on patient–provider relationships, patient attitudes towards care and, most importantly, patient outcomes. When culturally appropriate modifications are made in telepsychiatry, they should be tested to see whether they improve patient outcomes.

Acknowledgements: This work was supported by grant P60 MD000507.

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