

Correspondence

RE: An intercultural perspective towards supporting antipsychotic medication adherence in clinical practice

An intercultural perspective towards supporting antipsychotic medication adherence: is it all about medication?

I read with great interest Zacharia's Reflections article,¹ which provides an interesting and informative intercultural perspective on antipsychotic medication adherence, with a focus on people from minority ethnic backgrounds in the UK. I strongly support the argument put forward by the author for a 'relational/intercultural' approach rather than a 'cultural literacy' approach, especially in view of the limitations of cultural competence training and the impossibility of becoming familiar with all the cultures that patients may come from, as highlighted in the article. I was, in fact, left wanting to hear more about this 'relational/intercultural' approach proposed by Zacharia, which seems more humble, genuine, curious and person-centred than learning more about someone's culture through diversity and equality training. It also puts the clinician and the patient on equal footing, where the clinician is there to also learn from and be educated by the patient, and it puts the relationship between the two at the centre of the work. I would have liked to hear more about what this approach looks like in practice and how it can be taught and incorporated into routine history-taking, for example. It goes without saying that such an approach would be useful in engaging patients from minority ethnic backgrounds in general, beyond the issue of medication adherence. Herein lies my main criticism of the article: namely its overemphasis, in my view, on medication adherence as if it were a goal in its own right, especially in the context of people from minority ethnic backgrounds. Zacharia, rightly, highlights the 'need to think differently about how we support our ethnic minority patients'. The author does a very good job also at highlighting how explanatory models of illness that are accepted or adopted by ethnic minority patients may differ from Western explanatory models. He also shows commendable respect for 'informal' mental healthcare providers, such as faith healers and religious leaders, and he advocates engaging with them rather than ignoring them. However, the author's main focus seems to be on how we can use every method at our disposal to convince the patient to take medication. Zacharia's own cited figures show that 74% of patients discontinue antipsychotic medications after 18 months. This figure does not specify patients' ethnicity or cultural background, raising the question of whether addressing this issue in people from ethnic minorities specifically is justified, especially when the evidence suggests that patients from minority ethnic backgrounds are often overmedicated and are far more likely to be offered medication (including depot medication) than to be offered psychotherapy, compared with their White counterparts.² Furthermore, although the predominant understanding of the aetiology of mental illness in the West is a biomedical one, a large and growing number of clinicians, researchers and patients believe in more psychological and socioeconomic explanations, which are not too dissimilar to those adopted by some ethnic minority groups. These explanations seemed to be missing

from the dichotomy that Zacharia has drawn between Western explanations of illness (portrayed here to be the biomedical explanations) and metaphysical explanations adopted by certain minority ethnic groups. I therefore worry that equating Western understanding of the aetiology of mental illness with the biomedical model risks perpetuating a narrow perspective that has sadly dominated Western psychiatry, to the detriment of patients. The reference to the therapeutic alliance in the article is highly appreciated. Here again, however, the author overemphasises, in my view, the use of good therapeutic alliance in the service of medication adherence, when a good therapeutic alliance is in itself a vehicle towards improvement, not necessarily mediated by medication adherence. In other words, a positive relationship between the patient and his care coordinator, for example, will help his recovery even when the care coordinator does not use this positive relationship to convince the patient to take his medication. The author hopes that having more foreign-born or foreign-trained doctors and medical leaders may help clinicians towards cultural competences. I share his hope. My own observation, however, is that foreign-born or foreign-trained doctors are often reluctant to bring up their own culture or consider its relevance to the clinical encounter with patients, for example in educational spaces (case presentations etc.), assuming perhaps that they are here to learn Western medicine and that they therefore have to put aside such crucial and defining aspects of their identity as culture, ethnicity and religion. Balint groups may be a space where junior doctors could be encouraged to bring up issues of race, ethnicity and culture more freely and without fear of judgement. Finally, it is refreshing to see Zacharia advocating the incorporation of the patient's spiritual needs into the role of mental health practitioners. He goes on to suggest, quite rightly, that 'we must be ethnocentric in the mental health field', and that 'care may therefore require culturally appropriate framing. This may include spiritual or sociocultural interventions alongside antipsychotics'. Alas, the final quote appears only in the conclusion, right at the end of an article the focus of which has been on how to make patients from minority ethnic backgrounds take medication, and more medication.

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Declaration of interest

None.

References

- 1 Zacharia T. An intercultural perspective toward supporting antipsychotic medication adherence in clinical practice. *BJPsych Bull* 2023; **47**(1): 38-43.
- 2 Mclean C, Campbell C, and Cornish F. African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. *Soc Sci Med* 2003; **56**(3): 657-69.

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Author's Reply. RE: An intercultural perspective towards supporting antipsychotic medication adherence in clinical practice

Thank you for your thought-provoking response on 24 April 2023. I found your agreed emphasis on humility, genuineness and person-centeredness in the cultural learning within the clinician-patient relationship to be truly refreshing. By positioning clinicians as active learners, equalising the power dynamic and centralising the therapeutic alliance, the proposed approach aligns well with the principles of patient-centred care.

The discussion of how such an approach could be practically integrated into routine history-taking and other aspects of clinical care is important but, in my opinion, should not be stated too prescriptively as to stifle the naturally forming alliance between doctor and patient. The individual background and traits of the clinician are likely to affect the approach and, therefore, a 'clinician-centred' approach is required. Broadly speaking though, the introduction of cultural competence training in medical schools to promote engagement with these cultural aspects of the clinical-patient dynamic is vital, allowing the doctor to reflect on how their own culture and that of the patient can be used to strengthen the alliance.¹

I agree that Balint groups are a suitable opportunity to address issues of race, ethnicity and culture more freely. At GKT Medical School (King's College London), Balint groups are incorporated into medical student training (third year) and, through my experience as a co-facilitator of these groups, I have found medical students to often feel liberated by the unique opportunity to speak about the above issues in a reflective context while beginning clinical placements.

I share your concern about potentially overemphasising medication adherence as a standalone goal, especially when considering individuals from minority ethnic backgrounds. However, evidence clearly suggests the efficacy of anti-psychotic medication.² As this is an evidence-based treatment, it's important that we consider parity of care among ethnic minorities, and therefore the article promotes important discussion about tailoring a person-centred approach in this particular intervention. I agree, however, that more work is also needed to address non-pharmacological interventions.

The study you referenced by Mclean et al³ sheds light on the disparities in mental healthcare, indicating a tendency toward overmedication and a lack of psychotherapy options for these patients. It is crucial to take into account alternative explanatory models of illness, including psychological and socioeconomic factors, in order to provide a comprehensive understanding of mental health and optimise patient outcomes. By incorporating these perspectives, we can avoid perpetuating a narrow biomedical model that has sometimes dominated Western psychiatry to the detriment of patients.³

I agree with your appreciation of the therapeutic alliance as a fundamental component of effective care. Your point about a good therapeutic alliance serving as a vehicle towards improvement, independent of medication, aligns with growing recognition of the multifaceted nature of mental health treatment. For many patients, medication will remain an important aspect of achieving an optimal outcome.^{4,5}

Sadly, I agree a stigma often persists around foreign-born or foreign-trained doctors and medical leaders. A culture change within many National Health Service organisations is required. Cultural competence training, brave leadership and trust-wide culture-based reflective forums may be a starting point to open these discussions in a non-judgemental setting. We already recognise that foreign-trained doctors perform significantly worse in the CASC membership examination after controlling for educational and background variables.⁶ This perpetuates the idea that cultural differences in the clinician are unvalued.

Thank you once again for your thought-provoking letter, which highlights the significance of intercultural perspectives in mental healthcare. Your insights and recommendations serve as valuable contributions to the ongoing dialogue surrounding the provision of patient-centred and culturally sensitive care.

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Declaration of interest

None

References

- 1 Betancourt, JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep* 2003; **118**(4): 293-302.
- 2 Leucht S, Cipriani A, Spineli L, Mavridis D, Orey D, Richter F, et al. Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis. *Lancet* 2013; **382**(9896): 951-62.
- 3 Mclean C, Campbell C, Cornish F. African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities. *Soc Sci Med* 2003; **56**(3): 657-69.
- 4 Lambert MJ, Whipple JL, Hawkins EJ. Is it time to abandon the common factors paradigm? *Psychotherapy* 2013; **50**(4): 452-6.
- 5 Flückiger C, Del Re AC, Wampold BE, Horvath AO, Solomonov N. Which psychotherapy works for whom? A systematic review and meta-analysis of personalized treatment in psychotherapy. *J Consult Clin Psychol* 2018; **86**(6): 519-34.
- 6 Tiffin PA, Paton LW. Differential attainment in the MRCPsych according to ethnicity and place of qualification between 2013 and 2018: a UK cohort study. *Postgrad Med J* 2021; **97**: 764-76.

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