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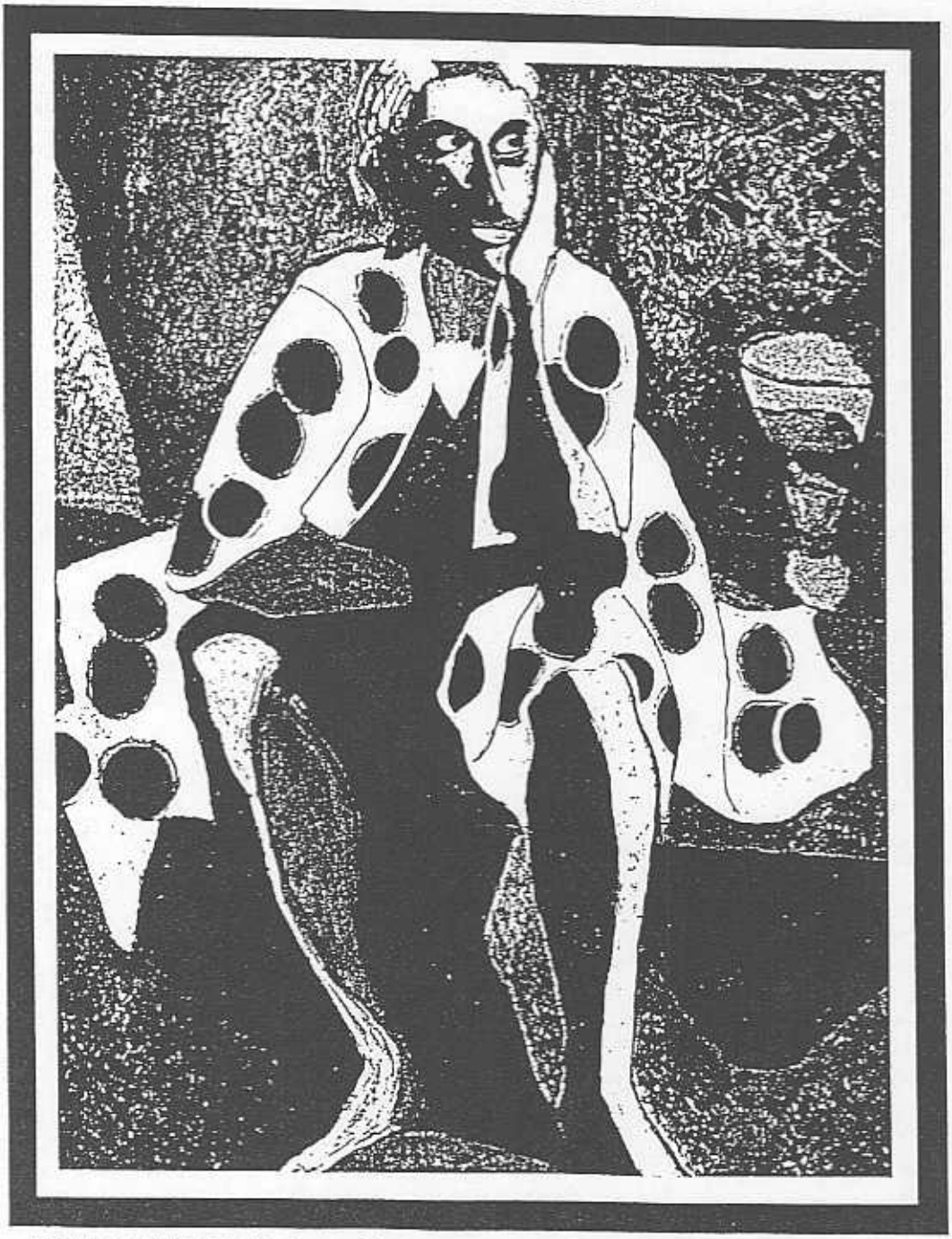

WILLIAM NGUYEN, "La Femme Fauve," 1994, acrylic. Courtesy Weisburd Family Collection.

PUBLISHER'S NOTE

by Dan E. Weisburd

Ernie Rodriguez, one of this issue's two co-editors, is a Ph.D. who directs a college psychological disabilities program. He is also a member of The JOURNAL Advisory Board, an insightful scholar, a good friend, and a proud individual very much in touch with his Latino heritage. Thanks to Ernie's efforts we were able to get some of our better authors for this issue. Not surprisingly, the people he brought in were African American and Asian/Pacific American, as well as Latino — because, true to form, Dr. Rodriguez has a community and a global perspective that matches his enormous sense of social responsibility. Without stealing too much of his thunder (you'll quickly see why he bats number one in our lineup), I feel compelled to quote a few of his powerful words: "Under the rubric of *we are all human* is the implication that *we are all the same* so there is no need to bring the uncomfortable issues of race and ethnicity into the relationship... *Anything* that has been a part of our experience shapes how we see the world, and culture is the most powerful of these influences...We must be able to talk about *the things that matter,* that are real in the life experiences of those we are trying to help, rather than to impose, either intentionally or unintentionally, our own definitions..." For me, those words are the keys that open the door to this issue...*The things that matter!*

Keh-Ming Lin, M.D., M.P.H., our other distinguished co-editor for this issue, is the Director of the Research Center on the Psychobiology of Ethnicity, and a Professor of Psychiatry at UCLA Medical School. Sharing his first person experience with a patient of Chinese ancestry, who had grown up in Jamaica as "a minority among minorities," Dr. Lin helps us to see *the person* — who is simultaneously a unique biological, psychological and socio-cultural entity. Then the good doctor, and the colleagues he has recruited, challenge us to grasp the influence of dietary factors as well as genetic endowment and culture, all played out against the powerful impact of an evolving, paradoxical, contradictory and demanding contemporary America that is itself in a period of unpredictable transition. Suddenly assumptions regarding medication non-compliance take on a different hue, and other key issues also demand reconsideration as we learn about new findings regarding rapid, extensive, slow and poor metabolizers, and how ethnicity imposes itself with enormous significance on treatment concerns and other unexplored intellectual territory that governs behavior.

Marv Southard, D.S.W., the new Director of Los Angeles County Department of Mental Health shares with us glimpses of his domain that at times seems to have been visited by extraterrestrials — L.A. — an international enclave that poses as a county, a linguistic Babel tower where diversity dares to strive for unity. Armenians and Iranians, Pakistanis, Arabs and Russians and other *new minorities on the block* all clamor for services, vying with the more established black, brown and yellow "people of color" who have for years sought their share of what they have felt was never satisfactorily available to them. "And what about the Native Americans...my Indian people?" asked JOURNAL Advisory Board member Glenda Ahhaitty, herself a Kiowa. Michael Aragon, the Pima tribe member she brought to this issue acquits himself forcefully as he makes *his* people's case. "Our people go over or under medicated. Little wonder that there are compliance problems. Where are the studies? Why are we so absent from the literature? Are we too few? Or too readily ignored?"

I look across the page at Della Wells' *"The Quilters."* In collage, young people of all colors putting together a new and different American flag. Could it symbolize the changing face of our 21st century increasingly multi-ethnic population? Will their overwhelming diversity and numbers once and for all render useless the old one size fits all mental illness care system, that — if the truth be known — hardly ever really worked for anyone, even we so-called *privileged* Caucasians? So many new questions. Or are they really just old questions that have never been adequately addressed? So many empty pages in our book of knowledge about the human brain. So little certainty. And now there is culture consciousness and its myriad implications on medications, metabolism, and psycho-social treatments.

Will research bring us answers? Who will do the research — where and when, and will it be done ethically without racial bias? And will it be transferable between cultures? Or will we — as so often has been the case in the past — learn mostly from our accidents and mistakes? Will we fumble and bungle our way toward discoveries, or is there a true path to progress? Has the scientific method ever taken us to a breakthrough or was it always the outrageous intuitive leap into the unknown by some quixotic, determined individual *who dared* that forced a paradigm shift? Future shock and culture shock are upon us...ready or not. ■

EINSTEIN'S NEMESIS: A Journey Out of the Abyss

by Keh-Ming Lin, M.D., M.P.H.

J.H. called the other day to schedule his semi annual appointment. When I saw him later that day, he looked a little thinner. Other than that, he really had not changed much. A couple of months earlier, an anesthesiologist had called to ask about the potential of drug interaction between the medicine he had been taking — 1 mg of Navane (thiothixene) — and some of the medications they were planning to give him for an operation he was going to undertake shortly. In a calm voice, J. H. told me that the operation had gone well, and he had also just completed a short course of irradiation.

"Why irradiation?" I asked.

"They found cancer," he said, "and wanted to minimize the chance of metastasis. Life really is not that bad otherwise," he added.

J. H. is a well respected ophthalmologist with a successful practice in the area. In his mid-fifties, he is in a stable marriage, is an active member of a number of Chinese American community organizations despite his busy practice, and is one of the most knowledgeable persons that I have ever known when it comes to matters of computers and Internet communications.

"And, by the way, do you know that you could watch CNN on the Net? Let me show you how to download the programs. All free!" he beamed, full of life.

His life has not always been easy. Growing up in Jamaica with Chinese ancestry tracing back to the latter part of the last century, he saw himself since childhood as a minority among the minorities. Things seemed to get better during his adolescence, after his parents decided to send him to the States for higher education. He did well in school, and enjoyed the freedom living in the U.S. While in medical school, he met his first wife, a nurse from Cleveland of German-Irish extraction. Although the marriage was not approved of by his family, things seemed to go quite well at the beginning. However, several years later, for unclear reasons, his world fell apart. Difficulties both at work and at home continued to escalate and he started to develop bizarre delusions involving complex plots from his wife's family and governmental agencies, resulting eventually in police intervention and involuntary psychiatric hospitalization.

In clinical encounters, one can never be very sure about why things work well at certain times with certain patients, and not as well with others.

His psychotic symptoms eventually were brought under control with the use of modern psychiatric medications. However, to this day he vividly remembers some of the traumatic experiences he went through while incarcerated in the hospital. Among these were multiple episodes of extremely distressing feelings such as painful muscle contractions (dystonia), restlessness (akathisia), shakiness (tremor) and a sense of being restrained (akinesia), that came along with the "miracle drugs" allowing him to regain contact with reality. For many months, he continued to struggle with the dilemma of whether to accept some of these side effects as necessary evils, or to risk the chance of a recurrence.

Divorced and utterly broke, he gradually restarted his career, and eventually was able to establish his practice in a different part of the country. Even though he ultimately stopped taking psychotropics, he remained functional for close to a decade. Then, seemingly out of the blue, things started to fall apart again. Delusions and bizarre ideation crept back, around the same time he made a number of bad financial judgments, which in combination with the recession, led to bankruptcy and the loss of his practice. Soon his house was foreclosed and he moved several times to progressively smaller apartments, either motivated by his delusions, or to save money, or both. Two years after the onset of his second breakdown, he finally exhausted all of his resources, and was seriously considering ending his life because "...*they* wanted to finish me anyway."

Throughout this period, his family in Jamaica kept an anxious watch. Several times different members of the family flew to Los Angeles to try to persuade him to restart psychiatric care. Remembering all the harsh experiences he had suffered during the previous episode, J. H. actively resisted. Still, the family persisted, and at this crucial moment, one of his older sisters came again from Jamaica, and somehow got hold of me. I'll never know how she managed to persuade him, but this was how I first became acquainted with J. H.

During our initial interview, J. H. was visibly suspicious and agitated. He believed that he had been under constant surveillance by the FBI, whose agents sneaked into his room whenever

KEH-MING LIN, M.D., M.P.H. is Director of the Research Center on the Psychobiology of Ethnicity at Harbor-UCLA Medical Center, and Professor of Psychiatry at UCLA Medical School.

n KM: Einstein's Nemesis: A Journey Out of the Abyss, The Journal of the California Alliance the Mentally Ill, 10:1, 1999.

he went out, and either moved things around or left trash in the room to confuse him. Because of this, he had stopped going out, and had run out of food and been starving for several days prior to the arrival of his sister. Much later, it would become clear that the reason (or one of the reasons, at least according to him) the FBI was after him was because he had "stumbled" onto a number of discoveries which if exposed would completely shatter the foundation of modern science, technology and the economy. Since the "establishment" had a vested interest in maintaining the status quo, "they" perceived his discoveries as dangerous threats and would do anything to stop him from exposing their "errors." Much later, after he started to trust me, he gradually revealed to me in detail how he could prove many of the modern scientific theories wrong. These ranged from ideas related to optic phenomena (after all, he was an ophthalmologist), the temperature at the core of the earth (cold, not hot), the non-existence of black holes, all the way to the greatest of his obsessions — that he could somehow mathematically prove Einstein wrong.

However, during that initial session, our (at least my) focus was much more mundane: I wanted to get him to agree to start taking medication and to see if there could be more stability in his living arrangements. The first goal was achieved by a compromise — I assured him that I could find a medicine at a dosage so (ridiculously) low that he would not even feel a thing, let alone any extrapyramidal side effects (EPS) such as those he had experienced previously. This was how he got started with the 1 mg of Navane. My (devious) plan was that once he started to take the medicine, it might be relatively easier to slowly inch up the dosage, hoping that EPS would not set in during this process. (Mind you, this was long before any of the atypical neuroleptics became available.) To my surprise and relief, each week he seemed to get a little better, and thus the issue of the upward titration never surfaced.

The other issue was stickier. With the help of his sister, he grudgingly agreed that it was not such a shameful thing to apply for governmental financial assistance. (He probably did not believe this would materialize anyway, given that the establishment was against him.) However, the process took nine months. Fortunately, with the help of a case worker, his sister found a board and care that was willing to accept him with postponed billing. With this lucky break, he no longer needed to worry about basic survival, and his outlook started to brighten.

The recovery process for J. H. was long and torturous. Although the extreme fear and worries subsided fairly quickly, he held on tight to his delusions — spending most of his time in subsequent months researching his various theories in the library. When the lump sum of the social security income finally arrived, he spent several thousand dollars, all that was left after paying off the board and care operator, on computer equipment, explaining that this would vastly enhance his ability to write his theses and send them to various academic departments around the country. However, soon he became increasingly excited about all the things he could do with this new toy and progressively less obsessed with his old ideas.

Examples abound where ethnic minority patients become more anxious or paranoid when seen by clinicians who have backgrounds similar to their own.

It took him a number of years to get his practice started again, and to get out of living the board and care lifestyle. It was even more of a struggle for him to start dating and eventually to meet and marry his current wife. All the while, whenever he encountered seemingly insurmountable obstacles, the old delusions would intensify and he would rage over the unfairness of the "establishment." Fortunately, FBI agents did not come back to haunt him, and these outbursts would eventually subside.

After several years, one day I realized that he had not talked about the "establishment" nor "Einstein's mistakes" for quite a while. I asked him about this, and he said, "Of course Einstein was wrong. However, I am now so busy with so many things, I no longer have time to think about that. Somebody else will have to."

J. H. has been in "remission" for quite some time. However, to be on the safe side, we decided that it was better that he continue to take the very small amount of Navane he started with. Since this has been largely "preventive" in nature, he only came for refill about twice a year. In addition, from time to time, he would call in a seemingly frantic state of mind, to talk about a new crisis that was overwhelming him. Most of the time, they were as mundane as arguments with his wife over which furniture to buy. However, a few times there were real tragedies, such as the accidental death of his stepson. Amazingly, he has been unusually resilient in dealing with these adversities and has not suffered from any recurrence of his previous psychotic condition.

While surprised and saddened by his cancer and the operation he had to endure, I was at the same time struck by how remarkably well he has been able to weather yet one more storm in his life, and make the best of it. I doubt if this were to happen to me (which in reality could happen any time), whether I could do as well. In this sense, he did not just recover from his illness; he became "weller," as Karl Menninger said so many years ago about some of his patients. J. H. again reminded me how often we are blinded by our immediate clinical experiences, which are of necessity weighted towards those who are least responsive to treatment and least likely to improve.

This said, it should also be pointed out that there were reasons all along why J. H. would have a better than average chance of recovery. He is

intelligent, disciplined and well educated. Suffering from his psychotic condition relatively late in his life, his personality had remained intact despite the onslaught of the disease. Above and beyond these personal attributes, he was graced with the unyielding support of his family. Throughout those desperate years they did not give up on him. They kept trying, and eventually were able to help turn things around, probably at the most critical points of his life.

In clinical encounters, one can never be very sure about why things work well at certain times with certain patients, and not as well with others. However, I suspect that the match in our backgrounds may have served some function, at least initially in engaging him in treatment. We are about the same age, have similar educational and professional backgrounds, and many life experiences. Although growing up from geographical areas almost on the opposite sides of the globe, we also share a common ancestral cultural root that might have helped to provide a sense of solidarity. To be sure, *clinician-patient match* and *culture-related transference* (and counter-transference) are complex issues that defy simplistic formulations. Examples abound where ethnic minority patients become more anxious or paranoid when seen by clinicians who have backgrounds similar to their own. In this case, fortunately, our shared background may have made it easier for J. H. to vent his frustration towards the "white establishment," and to explore issues related to his cultural identity. This single case of success does not mean that matching of the backgrounds between clinicians and patients is necessarily preferable, nor practical in our increasingly multi-cultural communities, it does, however, serve to demonstrate that these issues are extremely important and should not be brushed aside too easily.

Is 1 mg of Navane a "homeopathic" dose? I do not really know, and it ultimately does not matter, since J. H. did get better. However, in the last decade, there has been remarkable progress in research on factors responsible for determining what might be the optimal dose range of psychotropics for individual patients. It turns out that people vary a great deal in the way their bodies metabolize drugs (up to 100 fold in most cases). At the same time, the threshold at which their brains start to respond to chemicals also differs substantially. Such variability, is in part determined by one's genetic endowment, but is also influenced by environmental factors, such as diet, far more dramatically than previously realized. For example, the activity of one of the liver enzymes — CYP2D6 — can be divided into the following four groups:

Interestingly, the mutation patterns of the genes controlling the expression of practically all drug metabolizing enzymes, as well as genes involved in the function of the brain, typically show dramatic cross-ethnic differences.

- Ultra-rapid Metabolizers (UM)
- Extensive Metabolizers (EM)
- Slow Metabolizers (SM)
- Poor Metabolizers (PM)

Each is distinctively determined by unique genetic patterns: UMs possess multiple copies of the genes; SMs have mutations that considerably slow down the production of the enzyme (such mutations exist in up to 70 percent of East Asians and 40 percent of African Americans); PMs have no CYP2D6 gene at all, or they have defective genes leading to the production of useless molecules.

For a drug primarily metabolized by CYP2D6, the appropriate dose range for UMs may be hundreds of times larger than that needed for the PMs. Further complicating the picture, the distribution of these mutation patterns is remarkably uneven across ethnic groups, and a mutation that is highly prevalent in one ethnic group may be largely absent in another. Interestingly, the mutation patterns of the genes controlling the expression of practically all drug metabolizing enzymes, as well as genes involved in the function of the brain, typically show dramatic cross-ethnic differences.

Seen in this context, I now have reason to believe that 1 mg of Navane may indeed be the right dosage for J. H., and that he had been unnecessarily treated with excessively large amounts of psychotropics during his first hospitalization, resulting in experiences of severe and highly unpleasant side effects, and contributing towards his subsequent reluctance to resume the use of these modern day miracle drugs.

Luckily, with the rapid and continuing progress in the field of pharmacogenetics and molecular biology, standard testing methods may soon be available to assist clinicians to choose the right medicine in the right dose range, so that drug treatment in the future will be much more individually-tailored and ethnically and culturally appropriate.

It is a truism that we learn things constantly from our patients. Along with a number of other patients, J. H. taught me much about the co-existence of remarkable frailty and amazing resilience that is so much part and parcel of human existence, and about ultimately how similar we all are, irrespective of whether we carry one label or another. While in research we tend to parcel out clinical phenomena into artificially defined traditions, and there exist significant barriers in "bio-psycho-socio-cultural" integration, patients like J. H. constantly remind us that in life all these "dimensions" are never really separable. The only way we may be able to help them, and in turn help ourselves, is by being serious about all of these "dimensions," and the need to see beyond them — to see *the person* — who is simultaneously a unique biological, psychological, and socio-cultural entity. ■