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Contents

The following is an interview with Pedro Ruiz, M.D., on "Issues in Cultural Diversity," conducted by Vishal Madaan, M.D. Dr. Ruiz, Immediate Past President of the American Psychiatric Association, is Professor and Interim Vice Chair, Department of Psychiatry and Behavioral Sciences, University of Texas Medical School at Houston. Dr. Madaan is a fourth year psychiatry resident at Creighton University/University of Nebraska Medical Center in Omaha and the Resident Editor for this issue.

Dr. Madaan: **What are some of the challenges that American psychiatry currently faces, considering the pluralistic nature of the American population?**

Dr. Ruiz: In the last two decades the United States has become a multiethnic and pluralistic society. After War World II, a large number of migrants settled in the United States, and in the last two decades the impact of globalization on the U.S. and other industrialized nations across the world has been very significant.

Despite this multiethnic population growth, there are not enough psychiatrists and other mental health professionals from different ethnic backgrounds in the U.S. to provide appropriate and culturally competent mental health services that are required for those who have settled in this country. This situation presents a major challenge for the health/mental health care system of this country. Besides, issues pertaining to access, parity, and humane care are also major challenges when attempting to deliver high quality mental health services to these ethnic minority groups.

Dr. Madaan: **What are some of the recent initiatives that APA undertook to eliminate mental health disparities?**

Dr. Ruiz: During the APA Presidential year of Dr. Richard K. Harding (2001–2002), a special task force was organized under the leadership of Drs. Altha J. Stewart and R. Dale Walker to study and address on behalf of APA the U.S. Surgeon General Report on Mental Health Disparities in the United States. I participated in this task force, which produced a report focusing on a series of key issues pertaining to mental health disparities in the United States. Issues such as manpower needs, training and educational requirements, research limitations, and lack of access to care were all very well addressed by this task force.

During my Presidential year (2006–2007), I dedicated the funds for my Presidential Project to the creation of a manual that will address all relevant factors related to mental health disparities in this country. This manual is still being developed at the present time and will hopefully be finalized in 2008. This manual will also have a strong clinical emphasis.

Dr. Madaan: **What do you think are some practical ways of sensitizing psychiatry residents to cultural disparities and cultural competence?**

Dr. Ruiz: Unfortunately, there are not enough educational materials to educate and train all current psychiatric residents in this country in the areas of cultural competence and cultural disparities. In the 1990s, a series of articles were published that focused on the mental health needs and unique psychiatric care factors pertaining to a series of ethnic and/or minority groups residing in the United States. For instance, I was one of the authors of the article focusing on Hispanic Americans (1); other minority groups addressed in this series were Asian Americans, African Americans, and Gays and Lesbians. Recently, Russell F. Lim published an excellent book that addresses cultural competence (2); Drs. Wen-Shing Tseng and J. Streltzer have also published a book on culture competence (3), and my manual on mental health disparities is underway and will be published next year. These are three major educational and clinical tools directed to sensitizing psychiatric residents in the very important clinical and programmatic areas of cultural competence and mental health disparities. However, more needs to be done in this field.

Dr. Madaan: **What can training programs do to help International Medical Graduates (IMGs) culturally transition as they start their psychiatry residency?**

Dr. Ruiz: Psychiatric training programs are not currently doing enough in the orientation and preparation of IMGs who come to the United States to be trained in psychiatry. As a result of this, many IMGs face high levels of acculturative stress, and even occasionally psychopathological conditions as they cope and adapt to the educational and clinical demands faced during their psychiatric training in this country.

In this regard, appropriate role models and supervisors, extended periods of orientation, and several weeks of intense supervision and guidance are good methods of intervention. It might also be beneficial to have a special orientation in addition to the regular orientation that residents receive before starting their PGY-1 year.

A special situation also arises when IMGs begin to do psychotherapy during their residency training. A special seminar should be offered to them to address unique and important cultural issues, supplemented by an appropriate literature review

(4). Attention to the unique differences in ethnopsychopharmacological approaches should also be addressed through seminars and literature review (5).

It is also worth mentioning here the major contributions that IMGs make on an ongoing basis to the psychiatric public sector of the United States. For instance, in 1996, 32% of IMGs were working in the U.S. public mental health sector, while only 22% of U.S. medical graduates worked in this sector (6). This further emphasizes the need for training programs to be sensitive to the culture-specific needs of IMGs.

Dr. Madaan: **As we look ahead to the upcoming DSM-V, what are some major changes expected with regards to culture-sensitive diagnoses?**

Dr. Ruiz: With respect to the forthcoming DSM-V, much attention has been given to issues pertaining to the role of culture in the classification system. Plans are underway to have members with expertise in cultural psychiatry in all of the work groups assigned to the preparation of DSM-V. As far as culture-bound syndromes are concerned, they should certainly be addressed in DSM-V, not only as an Appendix, but as part of the axial system as well. Definitely, we have all learned from errors of omission in some of the previous editions of DSM, and it appears that DSM-V will most likely address these very relevant diagnostic dimensions. Furthermore, the APA should consider having psychiatric residents participate as observers in the DSM-V process. This kind of exposure will be an invaluable educational experience for our psychiatric residents in the United States.

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Residency in Psychiatry: Challenges for the International Medical Graduate

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Training in a residency program is an inherent step to establishing a career in psychiatry or one of its subspecialties. Residency training in itself is an arduous task, but it can be further complicated by immigrating to the United States and the subsequent cultural transition this entails. Since International Medical Graduates (IMGs) form a substantial percentage of psychiatry trainees, every training program needs to address this issue at some point (1). Interestingly, despite the changing and pluralistic face of America today, the literature on this issue is scant. In this article, some of the challenges that IMGs face as they undergo this transition are identified and possible solutions are explored.

1) Inequality of Opportunity: While most training programs mention and market themselves as "equal opportunity employers," research on the subject indicates numerous pressures on training directors to "buy American" (2). In an interesting study, Balon et al. report that residency programs respond differently to identical inquiries from potential applicants based on the perceived "foreignness" of the applicant's name and the location of the applicant's medical school (3). This perceived "foreignness" can lead to multiple complexities for the international applicant, based on the constituency of the program and its service needs and the applicant's fluency in the new language and awareness of the new culture, among other factors. Similarly, questions have also been raised regarding the fairness of the selection process, especially when comparing candidates from differing backgrounds, school systems, and/or methods of training. Another study indicates that when selecting individuals from foreign medical schools, medical licensure examination scores were given more importance due to a lack of reliable sources for other information (3). Similarly, it is a well known fact that the dean's letter for IMGs is far less descriptive of the individual's achievements and work ethic, compared with American graduates (4). This inconsistency may be more important in a specialty such as psychiatry, where factors such as personality, psychological stability, and self-awareness are more significant.

2) Acculturation: Acculturation is the process by which members of one cultural group adopt the beliefs and behaviors of another cultural group. This assimilation may be evidenced by a change in language preference, an adoption of attitudes and values common to the foreign culture, and a loss of separate political or ethnic identification. The IMG may struggle through numerous cultural and interpersonal differences when initially trying to adapt to the strangeness of the host country. The IMG may be subject to ambivalent sentiments of support and even hostility from American colleagues. Many IMGs feel resentment; others feel resignation, or may identify with the aggressor, consequently experiencing self-effacement and guilt (5). The decision of IMGs to stay in the United States or to return to their native country is often made in a piecemeal fashion; thus, IMGs may struggle to plan their future with certainty.

3) Issues in Psychotherapy: The cultural differences between IMG residents and their American patients have not been sufficiently addressed. These cultural and value differences may cause issues in patient management and the therapeutic relationship, including differing perspectives on boundaries, time management, and self disclosure, among others. In an interesting discussion, Triandis divided cultures into two basic types: collectivist and individualist (6). Each cultural type may have varying views regarding authority, relational style, and the status of the individual with respect to the community.

The basic unit of Eastern society is more often the family rather than the individual, so at times individual growth may become secondary to family integrity. Concepts such as hospitalizing young patients, thus separating them from their families, can be quite alien to the IMG. Therefore, while the patient may approach the psychotherapeutic process with the expectation of gaining independence and personal growth, the IMG resident may focus more on restoring social integrity. Similarly, IMGs, especially from southeastern Asia, may come from societies where intrafamilial conflicts are not explicitly expressed and hostility is repressed. For example, when dealing with patients in the process of difficult divorces, many IMG trainees may still focus on the possibility of persisting with the marriage. An article by Desai on the topic also mentions that an overriding concern about maintaining a positive relationship may deter an IMG trainee from confronting a patient regarding noncompliance (7).

On the other hand, IMG trainees are generally perceived by their patients as personable, warm, amiable, and readily available. IMGs may find the process of transference more easy to interpret, given an easier understanding of the impressions parents

make on a child and their adult manifestations (7). While other immigrants can reject a divergent belief system outright, the IMG psychiatry resident has to understand these differences and utilize them in improving the therapeutic alliance with his or her patients.

These cultural differences make the role of psychotherapy supervisor even more important. Supervisors helping with the psychotherapeutic training of an IMG resident must help the trainee deal with specific culturally-determined psychological assumptions. The supervisor must also help the trainee to open him or herself to new values and influences without becoming overly defensive. In this respect, appropriate role models and supervisors and intensive supervision and guidance is most beneficial. It might also be useful to have a special orientation in cultural issues, in addition to the regular orientation residents receive before starting their PGY-1 year. Residency programs must become more sensitive and aware of such issues, which can affect their trainees in more ways than one.

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Understanding Cultural Formulation

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With the growing cultural pluralism of American society, the issue of cultural competence has gained enormous significance for residents, who must understand and meaningfully apply this concept in their practice of psychiatry. This assumes even greater importance considering that International Medical Graduates account for approximately half of psychiatry residents in the United States. As clinicians, we must truly understand the psychopathology of our patients from a cultural standpoint and also identify how these symptoms affect their lives in a cultural context.

In realizing the importance of culture, we must first understand the meaning and depth of the term. "Culture" is defined as the system of shared beliefs, values, customs, behaviors, and artifacts that the members of a society use to cope with their world and with one another, and which is transmitted from generation to generation through learning (1). It is the systems of knowledge shared by a relatively large group of people. Cultural influences can be seen at various levels of society, including at the national level, regional level, gender level, generation level, social level, and corporate level.

An outline for cultural formulation and a glossary of culture-bound syndromes is provided in Appendix I of DSM-IV-TR. The purpose of the outline for cultural formulation is to identify important cultural contexts and to integrate these issues into a plan of care. It has been designed to assist the clinician in systematically evaluating the impact of an individual's cultural context on diagnosis and treatment. In realizing the impact of ethnicity and culture on psychiatric practice, we must find the appropriate methods for obtaining adequate information to develop an accurate cultural formulation.

Cultural formulation can be divided into five sections that intermingle and help in understanding the patient's psychopathology from a cultural perspective. The first component of cultural formulation establishes the "cultural identity of the individual." Cultural identity involves the blend of sociocultural influences that patterns the individual's cultural world. It is important to recognize the patient's reference group and subgroup characteristics. Also, it is important to understand what factors defined his or her migratory process; that is, whether the move was a personal choice or was forced due to circumstances out of the individual's control. The clinician also must clarify the patient's language abilities, use, and preference to know whether he or she may be able to express illness-related experiences and obtain care in his or her preferred language. In situations in which the language spoken by the patient is different from the psychiatrist, an interpreter must be involved in the evaluation. Furthermore, when defining cultural identity, we must incorporate other factors influencing personality development such as gender, class, religion, race, and sexual orientation.

"Cultural explanation of the individual's illness" is the second element of cultural formulation. This section examines cultural factors that affect the experience and interpretation of illness as understood by the patient, the family, and the social network. It is important to understand how symptoms or need for social support are communicated to family, friends, and mental health workers. Cultural factors help to create the illness experience and may affect cognitive, bodily, and interpersonal aspects of disease (2). It can help to shape the presentation of the patient, perceived etiology, severity, treatment choices, and outcome presentations (2).

The third component of the outline is "cultural factors related to psychosocial environment and levels of functioning." Clinicians can examine how culture patterns some of the stressors that patients are exposed to and their reactions to these situations. During this part of the assessment, the clinician can elicit the patient's traumatic experiences and how he or she incorporates these events into his or her interpersonal relationships. It is also important to note how social stressors as well as social supports impact the patient's presentation. Understanding the cultural background may clarify the origin and impact of the stressors that are being experienced. One should also consider how cultural identity contributes to the amount, nature, and quality of social support.

The fourth constituent of this outline includes "cultural elements of the relationship between the individual and the clinician." This section addresses individual differences in culture and social status between the patient and the clinician. These differences may cause problems in diagnosis and treatment and in determining whether a behavior is normal or pathological. Clinicians should be aware of and reflect upon their own attitudes and possible biases toward a patient's ethnicity and culture, as this may have a significant impact on the therapeutic relationship, as well as on the outcome of the treatment.

The final aspect of the formulation outline includes the "overall cultural assessment for diagnosis and care." This section summarizes information from the previous sections and discusses how cultural considerations specifically influence comprehensive diagnosis and care.

It is imperative for psychiatry residents to become familiar with the concept of cultural formulation in order to render an accurate diagnosis across cultural boundaries and to formulate treatment plans that are acceptable to both the patients and their families. The evaluation of patients from various ethnocultural backgrounds will assist residents in understanding how cultural factors impact various aspects of psychiatric illness, including symptom presentation,

treatment-seeking behavior, and treatment options. Furthermore, residents undergoing psychiatry training should understand culture-specific symptomatology that has been summarized in the second half of DSM-IV-TR, Appendix I, as culture-bound syndromes.

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