

## Guest Editorial

# Culture and Psychiatry, or “The Tale of the Hole and the Cheese”

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Few would dispute the proposition that culture makes a difference, whether in relation to detecting mental disorders, searching for their causes, or providing care for patients and their families. However, building a bridge from proposition to culturally competent actions requires conceptualizing intersections between culture and health that are not always immediately apparent and grounding research, practice, system planning, and advocacy in principles that do not translate easily into operational terms. This special issue addresses 3 conceptual bridges to help link proposition to practice: carrying out research, providing psychotherapy, and expanding the provision of mental health services.

This special *Journal* issue is particularly appropriate because, through a confluence of history, circumstance, and proclivity, Canada has played a preeminent role in developing the field of cultural psychiatry.

Since Confederation, somewhere between 15% and 20% of Canadians have been foreign born. Beginning in the 1970s, immigration shifted away from such so-called “traditional” source countries as the UK, the US, and Northern Europe; instead, people began coming to this country in increasing numbers from Asia, the Middle East, Latin America, and Africa (1). The theme of Canada as a “nation of immigrants” now resonates with a new harmonic, the harmonic of diversity.

Sociodemographic change, largely a result of the fact that 80% or more of all immigrants now come from nontraditional source countries, has directed renewed examination of this country’s commitment to equity. A commitment to equitable and excellent health care unites Canadians as few other contemporary issues do. However, despite the eradication of financial obstacles that make access to health care difficult in many other countries and despite documents like Section 12 of Canada’s Health Care Act, the Canadian Charter of Rights and Freedoms, and the Canadian Multiculturalism Act, ethnocultural status compromises access to, and excellence

of, mental health care. A recent report from the Office of the US Surgeon General documents race-based inequities in mental health care (2) and has been rightly hailed as groundbreaking. However, it is important to note that, more than a decade earlier, a Canadian government task force released a report dealing with the same issues (1). In a similar vein, a Canadian government report issued in 1990 provides guidelines for culturally sensitive mental health research (3).

Canadian institutions of higher learning have also played an important role in developing the field (4). For more than 50 years, the McGill University Department of Psychiatry and its journal, *Transcultural Psychiatry*, have been internationally recognized as leading influences in the field of cultural psychiatry. McGill’s activities in research and training have centred not only on domestic issues but also on developing collaborations with centres in other parts of the world. In more recent years, the Culture, Community, and Health Studies Program at the University of Toronto’s Department of Psychiatry has made similar national and international contributions to research and training in this field.

Psychiatric research can and does contribute to the work of clinicians and planners by opening up new treatment approaches, by providing the basis for evidence-based practice, by identifying areas of unmet need, and by suggesting the most effective allocation of resources to meet those needs. In this issue, my article on research (5) draws upon personal experience and the work of colleagues and students, as well as on formal publications, to illustrate some of the ways in which culture affects the purview of researchers, the conduct of research, and the implications of research findings. One of the article’s premises is that the fascination with difference that prompted early scholarship in this field must be balanced by an equal emphasis on searching for commonalities—for ways in which problems, solutions, and resources can be shared cross-culturally and cross-nationally.

My conviction regarding the importance of cross-cultural commonalities was reinforced by a January 2003 trip to Ethiopia. Several colleagues and I visited Addis Ababa University to explore ways in which the University of Toronto Department of Psychiatry might collaborate to help address a situation in which 11 Ethiopian psychiatrists are struggling to meet the mental health needs of a country with a population of more than 65 million. During the visit, we participated in courses on assessment and therapy that are part of the curriculum for the first class of psychiatric residents to be trained entirely in Ethiopia. There are many points of convergence: our Ethiopian colleagues are familiar with the signs and symptoms of many of the psychiatric disorders described in the DSM-IV and ICD-10, which are used in Toronto as the basis for psychiatric assessment. The accepted importance and use of pharmacotherapy also provided a common meeting ground. The residents were, however, notably sceptical about the value of psychotherapy. In their opinion, psychotherapy might be useful for North America's and Europe's "worried well," but it would at best be a luxury for a country with overwhelming and truly serious mental health problems. Although a few Westernized people might benefit from psychotherapy, according to the residents most Ethiopians would find the practice incomprehensible. Leaving the issue there would be unfortunate: psychotherapy is a rapidly developing field, and the techniques subsumed under this broad umbrella encompass some important approaches to helping people with distressing and disabling conditions. Further, as Dr Kenneth Fung and Dr Tat Lo point out in their paper in this issue (6), psychotherapeutic principles are at work in any clinical encounter. Psychotherapy is difficult to conceptualize and to operationalize in cross-cultural terms. Fung and Lo's paper draws on the authors' rich clinical experience to present an original and useful framework for clinicians working with patients having cultural backgrounds different from their own, whether within Canada or abroad.

During her lecture to the residents and faculty in Ethiopia, one of my Toronto colleagues, an expert in mental health systems research, lauded the attempts of the very small group of Addis Ababa psychiatrists to expand the mental health services network by training a large cadre of psychiatric nurses who are now stationed in clinics throughout the country. She rightly pointed out that, despite obvious differences in the magnitude of the problem, Canada shares with Ethiopia the joint problems of lack of resources and maldistribution of those available. In their article in this issue, Dr Laurence Kirmayer and colleagues comment on the viability of a system for extending culturally competent psychiatric services into settings other than the hospitals, specialized clinics, and private offices in which mental health expertise tends to remain concentrated (7). They present not only a compelling consultation model but also evaluative data suggesting its effectiveness.

Immigration experts used to refer to "immigrants" on the one hand and the "host society" on the other. The latter terms has

been dropped in favour of "receiving society." This is more than a matter of political correctness: the change in terminology connotes an important shift in thinking. Hosts rarely if ever change as a result of having guests. Societies do, however, change as a result of immigration and its attendant challenges as well as its opportunities for new learning. In a similar vein, it is increasingly uncomfortable to talk about "developed" and "developing" countries. Another story from our trip to Ethiopia will help illustrate why. After pointing to the similarities that Ethiopia and Canada share in responding to mental health needs at a population level, my colleague went on to say that reliance on traditional healing in Ethiopia as a substitute for, or adjunct to, health care is perhaps a factor that differentiates our respective societies. However, the fact that North Americans spend more every year on alternative or complementary medicines than they do on hospital care (8) suggests that my partner in this endeavour was wrong. Our Addis Ababa colleagues have probably studied the phenomenon of traditional care in mental health more carefully than we have in Toronto; this is only one example of many in which mutual learning can take place, provided that a healthy respect for the power of culture is maintained.

In his play *Mother Courage*, the famous German dramatist Bertold Brecht has a character say, "What happens to the hole when the cheese is gone?" Like the cheese that defines the hole, culture provides the context that imparts meaning to mental health phenomena, to theories about mental health, to what patients and their families expect, and to the struggle of mental health professionals to understand the human condition in ways that enable them to fulfil an obligation to deliver culturally competent service.

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