An Overview of Undergraduate Training in Cultural Competency and Cross-Cultural Psychiatry

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Multiculturalism is a familiar concept in many developed countries. While cultural competency training is part of most medical curricula, training in cultural psychiatry at the undergraduate level is typically minimal. It is important that medical graduates are both culturally competent and able to respond to the mental health needs of patients from diverse cultures. This paper provides an overview of the teaching of cultural competency and cultural psychiatry to medical students, and discusses aspects of cultural psychiatry that could be included in medical courses. It was concluded that there needs to be more attention given to teaching of cultural psychiatry in the undergraduate curriculum. The challenge for medical curricula is in the provision of cultural psychiatry content to ensure that students are able effectively to communicate, assess and treat patients from different cultural backgrounds by the time they graduate and begin their professional careers.

Introduction

Multiculturalism is a familiar concept in many developed countries. Most Western European countries, the United States, Canada, Australia and New Zealand have immigration policies that have enabled migrants, refugees and asylum seekers from around the world to resettle, both in response to global events including wars and natural disasters, and as a means for individuals to start new lives in a different country. In Australia, migration has played a vital role in population growth over the last 150 years and remains an important component of future demographic development. Our population currently stands at approximately 22.5 million, with the Australian Bureau of Statistics Population Clock estimating a net gain of one international migrant every two minutes (Australian Bureau of Statistics, 2011).

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Cognizant of our multicultural population, it is important that medical practitioners are culturally competent and effective in delivering services which appropriately reflect the diversity in ethnicity and culture that exists in Australia today. This paper discusses cultural competency training for medical students at undergraduate level, with a focus on the teaching of cross-cultural psychiatry.

Cultural Competency Training In Medical Schools

The term 'cultural competency' has become prominent in the medical education literature over the last ten years or so. Betancourt (2006) states that cultural competence aims to ensure that health care providers are able to provide quality health care to a diverse population:

> Physicians need a practical set of tools and skills that will enable them to provide quality care to patients everywhere, from anywhere, with whatever differences in background that may exist.

Betancourt (2006) believes that an effective approach to cultural competence training is to provide a practical framework within which to communicate with patients regarding how their social, cultural, or economic factors influence their health values, beliefs, and behaviours. Betancourt also underscored the importance of recognizing heterogeneity *within* cultures, to avoid the oversimplification of differences between patients of similar culture and background.

It is likely that almost all medical schools in the developed world incorporate some level of cultural competency training into their medical curricula. In Australia, for example, cultural competency is endorsed by the Australian Medical Council (AMC), and in order to meet accreditation requirements, medical courses must provide some level of training in this area (Australian Medical Council, 2010). In its goals of medical education, the AMC states that doctors must be able to 'work effectively, competently and safely in many cultural environments, including Indigenous environments'. This statement stipulates that graduates completing basic medical training should have knowledge and understanding of:

> Systems of provision of health care in a culturally diverse society, including their advantages and limitations, the principles of efficient

and equitable allocation and use of finite resources, and recognition of local and national needs in health care and service delivery.

Medical graduates should also have knowledge and understanding of Indigenous health and with regards to professional attitudes, and should demonstrate 'respect for community values, including an appreciation of the diversity of human backgrounds and cultural values' (Australian Medical Council, 2010).

Accreditation requirements for medical schools internationally are similar, and while these outcomes ensure that cultural competency is included in curricula, there is considerable variation in the content and approaches used between medical schools (Dolhun, Mun˜oz, & Grumbach, 2003). A survey of U.S. medical schools found that most provided inadequate teaching of cultural issues, with only 8% having dedicated units that specifically addressed these issues (Flores, Gee, & Kastner, 2000). Cultural issues are often incorporated into a few lectures, or are taught as part of a separate unit or elective.

Not surprisingly, students who undertake units/modules that focus specifically on culturally competence have greater awareness and understanding of cultural issues. An evaluation of a cultural competency unit at the New Jersey Medical School found that it was effective in improving students' attitudes towards both assessing the health beliefs of patents and towards understanding the importance of the patient's perspective in the provision of health care (Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004).

A two year programme, the 'Global Multiculturalism Track', run by the University of Massachusetts, also showed positive results. Objectives of this programme were to teach students to speak the language of an immigrant group; have an understanding of the difficulties that new immigrants have; develop an understanding of the culture and health of immigrants and the problems they face in accessing health care; and, promote a career preference to work with multicultural populations. An evaluation of this programme indicated that Track students maintained higher levels of cultural competence than non-Track students in the areas of providing comfort to, and being knowledgeable about, patients

of other cultures (Godkin & Savageau, 2001). A cultural diversity training module at the University of Leicester in the U.K. was similarly found to be successful in teaching students to respect differences between different groups of people and to address their own prejudices (Dogra, 2001).

Other studies have suggested, however, that informal learning opportunities may be more important than formal learning modules in developing cultural competency. A focus group study of medical students at the University of California that aimed to assess views towards the cultural competency curriculum indicated that while students regarded both the informal and formal curriculum as useful and relevant, the informal curriculum was seen as a more important source of learning about cultural competence. This included learning about cultural competence from residents, physicians and patients during clinical contact time, as distinct to lectures, standardized patient modules and required readings contained in the formal curriculum (Shapiro, Lie, Gutierrez, & Zhuang, 2006).

Several conceptual approaches and frameworks have been proposed for teaching cultural competency at undergraduate level. Kripalani and colleagues (2006) put forward three key areas to be covered by a curriculum – knowledge based programmes which focus on definitions of culture, social determinants of health and the epidemiology of various diseases among different cultures; attitude based programmes which aim to improve awareness of socio-cultural factors on patients values and behaviours; and skill building educational programmes which focus on learning communication skills to assist students with determining diagnoses, treatment and management plans (Kripalani, Bussey-Jones, Katz, & Genao).

Rapp (2006) described a framework for cultural competency training based on three different components. The first of these was the creation of early classroom experiences to teach students the basic principles of culture and cultural diversity. The second component of the framework stipulated the need for opportunities to engage in continued training of these early concepts throughout the pre-clinical years. It was further stipulated that this must follow through to the clinical years of the

course. The third component stipulated that knowledge and skills must be adequately assessed and evaluated throughout the course.

In Australia, New Zealand and North America, the term *cultural competency* is often associated strongly with both the Indigenous peoples, and those from culturally and linguistically diverse backgrounds (CALD) (i.e., those who have emigrated from other countries). Some of the issues that relate to Indigenous people compared with those from CALD backgrounds are distinct. It is important that students have an understanding of this, and that teaching reflects these unique differences.

Anthropology And Cross Cultural Psychopathology

The contribution over the last century of anthropological research to the understanding of cross cultural psychopathology is well established (Kleinman, 1987). The concept of cultural psychiatry as one of the cornerstones of modern psychiatry was introduced by Favazza and Oman in 1978. Their overview of the foundations of cultural psychiatry described the cultural dimensions of psychiatric concepts which were identified as an understanding of mental health and illness; child rearing and basic personality; cognition; family and social networks; sex roles and behavior; alcohol use; communication; and therapy(Favazza & Oman, 1978). At that time, Favazza and Oman stated that in terms of the study of culture, the challenge for cultural psychiatry is the development of a research base that focuses on the etiology of mental disorder in different cultural groups. Kleinman, writing in the late eighties, explored the applicability of classification and diagnosis to the portrayal of symptoms and identification of disorders in a cross cultural context (Kleinman, 1987). He concluded that diagnostic validity was one of the major issues in the attempt to categorise psychiatric phenomena among different cultural groups to standardized criteria and classification systems. The manifestation of psychopathology differs considerably between different cultural groups, and this remains as one of the challenges for clinicians working with patients from different cultural backgrounds.

Psychiatric Symptomatology In Different Cultures

Many languages do not have words that can be used as a meaning for 'depression' in the Western sense, but that is not to say that people do not experience feeling of sadness and low mood that can be attributed to a depressive episode (Bebbington & Cooper, 2007). The Western medical model of understanding, diagnosing and treating mental illness as a distinct area of health is not always suited to people from diverse and Indigenous cultures. For example, in an Australian Aboriginal context, the concept of social and emotional wellbeing describes an holistic view of health recognised by many Aboriginal people. Traditionally, health encompasses more than just the physical health of an individual – the social, emotional, spiritual and cultural wellbeing of the whole community is essential for the good health of individuals within the community (Garvey, 2008).

In other cultures, behaviours that would be considered 'abnormal' in a Western sense are considered appropriate within a wide range of social norms for that culture. For example, people in many parts of the world may experience being possessed by spirits and hearing voices talking or conveying messages to them. While in a Western model, this type of behaviour could be interpreted as symptomatic of psychosis, in some countries it is not taken as evidence of mental illness (Helman, 1994). In China, rates of depression are significantly lower than in Western countries, in part due to denial of symptoms and a tendency to express depression somatically. The prevalence of neurasthenia however, is much higher. Neurasthenia is a nervous system disorder characterised by fatigue, weakness and physical and psychological symptoms, and is less stigmatising and a more acceptable diagnosis than psychiatric disorders, which are seen as being a 'weakness of character' (Parker, Gladstone, & Kuan, 2001).

Prevalence Of Mental Illness Among Migrants

The process of migration itself can be a stressful experience for many people and may increase the risk of subsequently developing mental illness (Bhugra, 2004; Bhugra & Jones, 2001). Integrating into a new country, dealing with language barriers and an unfamiliar way of life

combined with existing personality traits and psychological factors can precipitate the development of psychiatric problems.

Studies on the prevalence of disorders in migrant populations who have resettled in Western countries are inconclusive, with some finding higher rates than the general host population and others lower rates (Bhugra & Jones, 2001). A review highlighted methodological issues related to research on the prevalence of psychiatric problems among migrants with difficulties including differences in definitions and terminology, assumption of homogeneity between migrant groups and a lack of standardization in the measurement of psychiatric symptoms (Lindert, Schouler-Ocak, Heinz, & Priebe, 2008). This has resulted in difficulties in determining accurate estimations of rates of common mental disorders such as depression and anxiety as well as suicide and substance use. Migrant children have been found to be at higher risk of developmental delays and poorer educational outcomes, and also have high levels of psychiatric morbidity (Derluyn, Broekaert, & Schuyten, 2008; Leavey et al., 2004).

Among refugees who have resettled in Western countries however, there is more compelling evidence of mental disorder prevalence. Rates of post-traumatic stress disorder, for example, are estimated to be about ten times higher than in the general population (Fazel, Wheeler, & Danesh, 2005). Poor mental health is also associated with asylum seekers detained in immigration centres (Robjant, Hassan, & Katona, 2009). Severity of symptoms is correlated to time spent in detention with increasing severity seen in those who have been in detention for longer periods of time. For children who have been detained, even after release into the community, high levels of psychological distress persist for several years (Robjant, et al., 2009).

Cultural Psychiatry Training In Medical Schools

The wide variation in the perception and expression of mental illness among different cultures and ethnicities presents challenges in both medical curricula and the provision of mental health services. While it may be argued that cultural competency training in psychiatry is a post graduate concern, it is nonetheless important that medical schools cover

the key issues of culture relative to psychiatric practice, particularly when students are in the clinical years of their training and working in hospitals and community settings.

While teaching cultural competency has become mandatory in many medical courses, training in cultural and ethnic issues in psychiatry is minimal, and undertaken in only a few courses (Qureshi, Collazos, Ramos, & Casas, 2008). More attention is given to cultural psychiatry at a postgraduate level with these curricula becoming increasingly responsive to the need to introduce cultural content to their courses (Boehnlein, Leung, & Kinzie, 2008; Fung, Andermann, Zaretsky, & Lo, 2008).

Although in a crowded curriculum it may not be feasible to provide medical students with a comprehensive education in cultural competency in psychiatry, the salient points should at least be covered. These include an awareness of the ways that culture impacts on the expression and understanding of mental distress at an individual level, and limitations in applying standardized diagnostic classification systems to people of different ethnicities. In addition, understanding the importance of effective communication skills is imperative in developing a therapeutic doctor-patient relationship (Qureshi, et al., 2008).

Cultural competency training is best suited to the pre-clinical years of the medical course, (Rapp, 2006) but it is also important that students are provided with frequent opportunities to practice and revise these skills as they progress towards the clinical years of their training (Kripalani, et al., 2006). While there is evidence that cultural training at postgraduate level is effective (Boehnlein, Leung & Kinzie, 2008; Kirmayer, Rousseau, Guzder, & Jarvis, 2008; LoboPrabhu, King, Albucher, & Liberzon, 2000) research into its implementation, impact and effectiveness at an undergraduate level is limited. It would seem likely that the successes at postgraduate level could be replicated in undergraduate courses and more emphasis needs to be given to this in medical curricula.

Conclusion

The endorsement of cultural competency training by accreditation bodies internationally, dictates that medical training must be responsive to culturally diverse populations that are characteristic of many countries. While training raises student awareness and knowledge of cultural issues, the extent to which this is provided is variable, ranging from a few lectures or tutorials to complete modules and units.

Cultural competency training is part of most medical curricula, however, provision of training in cultural psychiatry is often minimal. Some suggestions that may assist students in developing cultural awareness in psychiatry include, an understanding of the ways that culture and the expression of psychiatric symptomatology impacts on diagnosis and treatment; awareness of problems that can occur with language barriers and working with interpreters; awareness of the concept of extended family and support structures; spiritual aspects of treatment and management; and, the use of traditional healing practices.

As students progress through the clinical years of their training, exposure to cultural issues is inevitable, through both work on hospital wards and in community settings. It is especially important that they have the knowledge and skills to deal with situations that may arise during contact with mentally ill patients to ensure that cultural beliefs and differences are recognised and understood. Courses need to improve training in the area of cultural psychiatry. The challenge for medical curricula is in the provision of cultural psychiatry content to ensure that students are able to effectively communicate, assess and treat patients from different cultural backgrounds by the time they graduate and begin their professional careers.

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