The Evolution of Cultural Psychiatry
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Guest Editor

Our ability to reach unity in diversity will be the beauty and the test of our civilization.
—Mahatma Gandhi

The relatively young field of cultural psychiatry has had many iterations over the years. Lawrence Kirmayer, a Canadian cultural psychiatrist, chronicled these changes, including the field’s contemplation of the universality of psychopathology and treatment, the focus on providing mental health care to ethnically diverse populations, and analysis of psychiatric theories. For a portion of this history, cultural psychiatry has emphasized the mental health of nonmajority populations through the identification and description of select “culture-bound syndromes,” which reflect on mental illness through the lens of colonialism and Western majority populations. More recently, emphasis has been placed on training clinicians to develop cultural competence in dealing with diverse patient populations. And now, evolving concepts in cultural psychiatry emphasize the elimination of inequity by understanding the impact of the social determinants of mental health and by developing structural competence. This issue of Psychiatric Annals considers the historical perspectives of cultural psychiatry and focuses on its current goals.

Psychiatrists begin their educational journeys on a quest to become competent, knowledgeable physicians. We seek complete understanding of biochemistry, pathophysiology, and neurosciences. Medical school curriculum does not traditionally include courses in anthropology, sociology, and ethnic and women’s studies. In college, I overlooked those courses to meet the prerequisites for medical school, which seemed more important at the time. Now, having interacted with patients of diverse and marginalized backgrounds for over 15 years, I realize that my medical education and training did not adequately prepare me for the breadth and complexity of the relationships between my patients, other mental health professionals, and societal structures.

Despite significant advances in the recognition and treatment of mental illnesses, certain underserved populations have persistently poor outcomes. We are beginning to understand intersectionality in mental health—how class, race/ethnicity, gender, sexuality, and other factors interact to create a landscape where some people with serious mental illnesses die up to 25 years earlier than the general population, and jails and prisons are the major purveyors of public mental health services in this country.

What is the precise role of the psychiatrist in addressing these inequities in mental health? And what role does cultural psychiatry play, in particular? Cultural psychiatry provides a framework for considering these often overlooked but vitally important issues in our society. In this issue, we attempt to delve into these difficult concepts through the lens of cultural psychiatry, and we endeavor to consider new solutions to old problems.

We set the scene with the Case Challenge “A Young Transgender Woman with Fatigue, Malnutrition, and a Previous Suicide Attempt” by Dr. Rachel Robitz, Dr. Amy Gajaria, Dr. Hanni Stoklosa, Ms. Ebony Jones, and Dr. Susie B. Baldwin; they describe a common scenario that highlights the importance of considering a cultural psychiatry framework in clinical encounters. The article also
The globalization of psychiatry exemplifies the importance of collaboration with community members, advocates, and people with lived experience, as they bring an unmatched insight and expertise to both clinical and community settings.

The first continuing medical education article, “Inequities in Mental Health and Mental Health Care: A Review and Future Directions,” by Drs. Christine E. Kho, Jann Murray-García, and myself provides an overview of mental health disparities and inequities. We conceptualize new methods for addressing disparities and inequities by focusing on the social determinants of health, implicit bias, and structural discrimination.

In the next article, “Education, Training, and Recruitment of a Diverse Workforce in Psychiatry,” Drs. Swati Rao, Poh Choo How, and Hendry Ton focus on the role of cultural psychiatry in the education of students, residents, and practicing psychiatrists. They discuss innovative models to enhance diversity, eliminate disparities, and promote social inclusion. Practical applications for implementing and improving cultural skills in clinicians’ practice and educational settings are also provided.

The globalization of psychiatry has the potential to inform the delivery of mental health services in diverse settings closer to home. In the article, “Implications of Global Mental Health for Addressing Health Disparities in High-Income Countries,” Drs. Anna Fiskin, Megha Miglani, and Colin Buzza discuss the interactions between global psychiatry and cultural psychiatry, and how lessons learned from providing quality mental health services in under-resourced international environments may lead to advances in addressing inequities that persist in the United States and other high-income countries.

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Finally, in the article “The DSM-5 Cultural Formulation Interview: Bridging Barriers Toward a Clinically Integrated Cultural Assessment in Psychiatry,” Drs. Ravi DeSilva, Neil Krishan Aggarwal, and Roberto Lewis-Fernández discuss the clinical relevance of The Diagnostic and Statistical Manual of Mental Disorders, fifth edition, Cultural Formulation Interview (CFI) and provide insight into how providers can better incorporate the CFI into their clinical practice, as well as why it is so important to do so.

Before delving into these articles, I would like us to briefly consider language and its use in this issue. Language can be a powerful tool for enhancing communication, but it can also be a source of division and disagreement. Throughout this issue, words that have the potential to unite us or stir conflict will be used. Examples include: stigma versus social norms; victim versus survivor; disparities versus inequities; and Latino/a versus Latinx. The authors have attempted to be as respectful and inclusive with our language as possible, but we recognize that we will invariably fall short of achieving our goal of complete inoffensiveness. The topics in this issue are hard to discuss, for many reasons, but partly because of fear of saying the wrong thing. We cannot let this deter us from more deeply exploring these themes or from striving to make things better.

Author and social activist bell hooks once said, “Our mental well-being is dependent on our capacity to face reality. We can only face reality by breaking through denial.” To a degree, we psychiatrists have been operating in a form of denial, ignoring our role in trying to address persistent inequities seen in our communities. It is my hope that this issue will help us begin, as a field, to break through our denial and move toward more comprehensively considering the role of culture in clinical practice and beyond.

REFERENCES

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Dr. Shim received her master’s in public health degree in health policy from Rollins School of Public Health at Emory University and her medical degree from Emory University School of Medicine. She is board certified in psychiatry and is a Distinguished Fellow of the American Psychiatric Association, a member of the American College of Psychiatrists, and is Chair of the Fellowship Committee of the Group for the Advancement of Psychiatry. She is a member of the National Academies of Sciences, Engineering, and Medicine’s Committee on Changing Behavioral Health Social Norms through Messaging for the Public. She serves on the editorial boards of Psychiatric Services and American Psychiatric Publishing, and is co-editor (with Michael T. Compton, MD, MPH) of the book, The Social Determinants of Mental Health.

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