Recently, I traveled to China, carrying a suitcase heavy with copies of the American Psychiatric Association's Practice Guidelines, a donation for the Peking Medical School. Observing my struggles in Beijing to overcome the language barriers and connect with a Chinese psychiatric colleague, my non-medical traveling companions raised the question, "Of what possible use can American psychiatric treatment guidelines be to the Chinese?"

In our 2 weeks of travel, we had all become instant experts on Chinese politics and culture. It was natural to wonder about the relevance of Western psychiatry in a paternalistic society where we had learned that the rules of government dictate life decisions (e.g., one child per urban family, the obligation to work when and where one is directed, and restrictions on communication). Their questions gave me an opportunity to enlighten them about the development of DSM-IV and the various aspects of our diagnostic and treatment work that transcend cultural issues. "Schizophrenia, depression, and paranoia know no cultural boundaries," I told them.

However, their original question was a good one. These psychiatric illnesses may exist around the world but their identification can often be blurred by cultural issues. Once a diagnosis is established, transcultural issues can also influence the goals and outcome of treatment, including psychotherapy.

This was brought home to me a number of years ago when I was a volunteer in Vietnam with CareMedico. One day, the Chief of Surgery at a large city hospital in Saigon (now Ho Chi Minh City) implored me to evaluate a hospital attendant. According to the surgeon, the young man had made frequent unsuccessful suicide attempts, trying to hang himself in one of the operating rooms. "Please," the surgeon pleaded with me, "talk with him, find out why he does this in the operating room, and get him to stop!" (For some unexplained political reason, the surgeon was unable to remove the young man from his job. It was therefore imperative to find some other solution.) Working with a translator, I interviewed the man. He was in his early thirties and was neatly and simply dressed. He sat passively with his head hanging down and his eyes averted. I attempted to develop a therapeutic alliance, while working my way through a diagnostic interview. My questions were met by monosyllabic answers which revealed nothing of the man's thoughts or motives. I formed the naive opinion that he was experiencing some type of paranoia as well as severe depression. Only later in talking with the interpreter did I realize that his posture, demeanor, and refusal to make eye contact were all characteristic when someone from his social class met with someone like me, a physician! Although the definition of paranoia may be the same the world round, its diagnosis is not as easily made in Vietnam by an outsider, even if one has traveled almost the world round.

Just as the interpretation of communications is influenced by cultural expectations, so is our understanding and appreciation of culturally driven behaviors such as the freedom to express emotion, the intensity and obligations of family attachments, and belief in self-determination.

This man's behavior and my misinterpretation of it are not that unusual. In describing the reactions of Vietnamese, Dien and Lipsedge write that "Questions asked by professionals can be interpreted as intrusive. This reluctance to speak may be misdiagnosed as suspiciousness or being guarded and may result in the prescription (by an unwaried Westerner) of more medication." Just as the interpretation of communications is influenced by cultural expectations, so is our understanding and appreciation of culturally driven behaviors such as...
the freedom to express emotion, the intensity and obligations of family attachments, and belief in self-determination. In a recent meeting with some young psychiatrists, we were discussing a patient's manner of expressing anger as revealed in a videotaped interview. During the interview, the therapist was trying to direct the patient to be more aware of her anger and express it openly and directly rather that denying its existence to both herself and others. A number of the psychiatrists sitting around the table came from several different cultures. I asked what their reactions were to the psychiatrist's interventions and what their cultural expectations were in terms of the open expression of feelings. In this small survey, the psychiatrists from Armenia and Eastern Europe said that the open expression of feelings was a natural, expectable occurrence, whereas those from India and the Philippines were uniformly more reserved and self-contained.

People who enter the psychiatrists' consultation room in our multicultural world may be struggling with the transitional process that is part of immigration.

Given these differences, it is conceivable that one can accurately assess the meaning of patients' communications as well as their affect and demeanor when working with people from different cultures? And what is the fate of the goals put forth by the various Western psychother apies? Can psychiatrists diagnose and provide appropriate psychotherapy for those who come from a world far apart from their own?

These questions are real puzzles that need to be carefully understood by psychiatrists. Yi has raised important questions about the applicability of a number of theoretical and clinical principles, identifying what he sees as conflicts between East Asian and Western Cultures that affect psychoanalytic theory and treatment goals. He describes the Western self as independent, but says that Asians have a "communal sense of self." In his view, the Western self is interior, whereas "for Asians, selfhood is found not so much in the person's interior as in his/her public interpersonal relationships... the private or interior self is usually kept backstage or within the family" and "the Asian... self... requires others, but in the opposite manner (from the Western)... the self needs to orient itself to the needs of others for healthy development." These postures raise questions about the place of techniques such as assertiveness training and developmental theories such as separation/individuation when applied to the treatment and understanding of those with different cultural antecedents.

In addition to the differences that have been described, the people who enter the psychiatrists' consultation room in our multicultural world may be struggling with the transitional process that is part of immigration. Akhtar writes knowledgeably about the psychological outcome of immigration, describing the developmental tasks inherent in the transition. He describes four interlocking strands in the fabric of identity change:

1. dimensions of drive and affect
2. interpersonal and psychic space
3. temporality
4. social affiliation.

It is clear from his writing that he sees a successful transition as one that involves both giving up and grieving for certain elements that are part of the old and accepting aspects of the new; as well as a movement from "yesterday or tomorrow to today." Success is characterized by good-humored ambivalence toward both the country of origin and that of adoption. An unsuccessful transition would lead one to cling to idealized views of one's native land and associate only with homoethic groups.

A recent article in the New York Times stated that 450 mosques exist in New York and Long Island alone and that Muslim schools are attracting hundreds of parents who are clamoring to have their children enrolled. This increasing Muslim influence not only represents parents who have immigrated from Asia, Africa, the Middle East, and the Indian subcontinent but also American-born converts. We might well ask, "What is the position of the psychodynamic psychiatrist in a search to enlighten and help free from conflict someone whose religious roots favor arranged marriages and strong rules of paternalism?"

The challenge for the psychiatrist is to understand when "reality" is a resistance and when it is a true cultural conflict. One patient may be made anxious by the very real cultural differences that exist between the world he grew up in and the one he has newly entered. Another patient may have made a successful transition and the presentation of cultural conflict is but a red herring masking more relevant developmental intrapsychic conflicts. The following case illustrates the second situation.

A college student who had lived in the United States for 6 years came to the outpatient clinic for treatment, describing the onset of serious symptoms of depression 3 months earlier. She attributed these depressive symptoms to separation from her family of origin in South America. In fact, this woman had made a very successful adjustment, working two jobs while attending a junior college.
However, she had transferred several months earlier to a major university where she had a much more difficult and time-consuming schedule. In this new situation, she was no longer able to maintain the high level of achievement that had always been demanded by her harsh punitive mother. Although she had traveled many thousands of miles away, the internalized superego demands remained the same. Her problems were not the result of cultural conflicts but were triggered by intrapsychic conflicts.

Psychotherapists need to be attuned to these distinctions. In their work, they may be called upon at different times to help someone walk, figuratively, through the stages of immigration, deal with crises for which cultural issues primarily serve as a backdrop, or recognize when the presentation of cultural issues serves to obscure a very different psychodynamic problem.

These are but a few of the culture differences we encounter in our day's work. They provide a brief glimpse into a subject with a vast literature. According to McKenzie and Crowcroft, about 2,500 papers are indexed yearly into Medline under the headings "ethnic groups" or "racial stocks." How can psychiatrists best prepare themselves to meet this challenge?

As with so many problems, the most important first step is to recognize that real differences exist. However, these differences in no way preclude the development of a working alliance. When I was a young psychiatrist, I worked for a time in London at the Tavistock Clinic. I was treating a woman in her mid-60s who had recently developed panic attacks. I was somewhat intimidated by this proper Londoner who was more than twice my age and who, I assumed, had little confidence in her "young American psychiatrist." I was encouraged by my Kleinian supervisor to push her to explore the transference relationship. My entree to the subject was to ask if she was uncomfortable with the fact that I was a foreigner (an inquiry based much more on countertransference than an appreciation of transference). To my surprise, she replied with great enthusiasm, "Oh, no—after all, Freud was a foreigner!" She had, in fact, been boasting to her friends that her psychiatrist was "a foreigner!"

Cultural sensitivity, openness to the expression of patients' reactions, willingness to learn about the differences, and respect for cultural and religious mores all play an important part in our ability to work effectively with those whose cultural background is different from our own. The fact that family relationships and obligations vary from culture to culture does not diminish the emergence of psychologically based developmental conflict. Much of our psychodynamic work is targeted at the difficulties patients have in living with different realities: dealing with the obligations of work, responsibilities of family, the pain of death and dying. One individual may quite comfortably remain immersed within the family while developing a sense of self. Another individual in the same situation may be severely conflicted, develop identity diffusion, and need psychodynamic work to emerge as a psychologically whole person. Similarly, obsessive and impairing adherence to political and social doctrines needs to be distinguished from culturally appropriate responses. Respect for the patient's religious affiliation does not prohibit dynamic exploration of what the religion means to the individual. A true working alliance provides space for the patient to inform and clarify facts about his cultural heritage for the psychotherapist, while simultaneously allowing an opportunity for the mutual exploration of the ways in which this journey from one culture to another creates conflicts and solutions. Culturally sensitive psychiatrists who approach each patient in a psychodynamically informed manner will increasingly widen their knowledge base, learning while helping an ever more diverse group of patients.

The fact that family relationships and obligations vary from culture to culture does not diminish the emergence of psychologically based developmental conflict.

References