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Training Psychiatrists for Global Mental Health: Cultural Psychiatry, Collaborative Inquiry, and Ethics of Alterity

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Awareness of the global burden of disease from mental illnesses, insufficient funding for services, and paucity of mental health professionals for low- and middle-income countries (LMIC) has spurred development of global mental health (GMH) curricula in psychiatry residencies. According to a recent study, 17 psychiatry residencies offer research and clinical opportunities in GMH. Most were offered through institution-wide, externally administered initiatives in which psychiatry residents could participate [1]. Learning objectives were mostly limited to acquisition of cultural competencies for care of patients from different ethnicities. As Belkin et al. ([2] p. 403) noted: (Table 1).

This emphasis on issues of cultural familiarity, as well as reinforcing certain trainee personal and professional attributes, such as empathy and flexibility of thinking, also reflected relatively less consideration of how a more synthetic, "globalized," field and frame of reference might shape and inform psychiatric knowledge, research, and practice.

Program descriptions and surveys have revealed various conceptualizations of GMH curricula without a unifying thread, except for international training focused upon disadvantaged populations [1, 2].

The mission of our George Washington University (GWU) GMH curriculum has been to educate psychiatrists for service in LMIC, in settings of disaster, war, and refugee crises, and with local immigrant and refugee populations in the USA. Residents first learn psychiatric care for immigrants and refugees in our local community, including treatment and advocacy for political torture survivors seeking asylum [3]. Learning how to design effective interventions that counter stigma is a major focus [4]. After acquiring sufficient competencies, residents design mental health service projects and research studies in LMIC countries and settings of refugee crises.

Compliance with Ethical Standards

Disclosure
On behalf of all authors, the corresponding author states that there is no conflict of interest.

Supplementary material
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As an educational foundation, we first drew six themes from the scholarship of cultural psychiatry and medical anthropology about contextual, cultural, and health systems differences between mental health services in the USA and those in LMIC, so that these themes could guide selection of curricular content. Second, we utilized collaborative partnerships with mental health colleagues who belonged to populations that we served so their critiques and commentaries could inform our educational aims. Third, most GMH teaching was embedded within seminars serving multiple educational roles for all our residents. Fourth, a Global Mental Health Track was designed to provide more individualized study programs for residents seeking advanced levels of GMH expertise. This approach has proven to be a pragmatic one for developing a GMH curriculum, which we can recommend for consideration by other US psychiatry residencies.

Strategy One: Utilize Cultural Psychiatry and Medical Anthropology Scholarship to Identify Contextual, Cultural, and Health Systems Differences Between the USA and LMIC that Impact Experiences of Illness and the Delivery of Care

Cultural psychiatry and medical anthropology scholarship have clarified essential differences between LMIC and high-income countries (HIC) of North America and Europe in terms of ethnopsychologies, psychiatric diagnoses, morbidity of psychiatric illnesses, and social suffering [5, 6, 7]. Six themes were selected that would complement, but not replace, training in evidence-based practices for treating severely ill patients, such as diagnostic psychopathology and psychopharmacology. Table 1 lists the location of each theme within our overall residency curriculum. Each of these six themes has been implemented through specific learning objectives and training experiences that also fulfill associated American Council for Graduate Medical Education (ACGME) Milestones (detailed in the SUPPLEMENTAL FILE and our departmental website www.gwupsychiatry.org).

I. First, do no harm. Adverse unintended consequences can accrue in LMIC and refugee populations due to differences in resources, status, and power between HIC mental health professionals and local recipients of services [8].

New dimensions of iatrogenic harm open when well-intended HIC clinicians and researchers enter complex LMIC psychosocial eco-systems. To avoid adverse unintended consequences, a global mental health curriculum needs to provide knowledge and skill sets for structuring collaborative, egalitarian, and dialogical relationships, so evidence-based psychiatric care is provided while preserving voice, agency, and cultural identity for LMIC and other GMH recipients [9, 10] ([11], p. 21) ([12], pp. 245–251). This requires attunement to power dynamics and differentials that shape interactions between HIC and LMIC actors within clinical, academic, and social settings.

II. Impaired mental health in LMIC and refugee populations is commonly due to social suffering and demoralization that may not represent psychiatric disorders, but whose psychiatric care requires specific skill sets [13].

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In LMIC, patients commonly present non-specific somatic symptoms or depression and anxiety symptoms that have proximal relationships to psychosocial stressors (6). Cultural concepts of distress (idioms of distress, cultural syndromes, and explanatory models) that a suffering person presents for treatment often reflect social context and may not correspond to DSM-5 diagnostic categories [6, 14]. Descriptive psychiatry has shown little effectiveness in organizing treatment for such symptoms [6, 15, 16]. HIC mental health professionals lacking understanding of local concepts of distress and societal roles for healers can do harm by introducing diagnostic and treatment approaches that fit poorly with local meaning systems or health care resources [6]. Patients may insist that their predicaments in living and subjective illness experiences be understood and acknowledged before treatment progresses.

III. Patients in LMIC may embrace identities that are family-, clan-, religion-, or ethnicity-based as primary identities.

Persons in LMICs may first see themselves as a family member or an ethnic or religious group member, rather than an individual [6, 10]. Determining which identity aspects are most important is crucial to respectful dialogue and successful clinical care [9]. Training in family therapy to learn systemic assessment, formulation, and intervention is key for effective clinical work [10].

IV. "Local biologies" influenced by infectious disease prevalence, diet, exercise, and genetic differences in pharmacokinetics influence psychiatric phenotypes and treatment response [17].

Local biology refers to how diet, physical activity, parasites and other infectious disease, other health burdens, and climate influence inflammatory responses and psychoneuroendocrine pathways that can shape psychiatric phenotypes [17]. Sensitivity to local biology must be combined with awareness of population genetic differences in medication pharmacokinetics to avoid risks from altered drug metabolism and interactions.

V. Mental health needs in LMIC vastly exceed the number of mental health professionals required to respond.

Major roles for a psychiatrist in a LMIC commonly are those of educator, supervisor, and consultant to primary care clinicians and community health workers who, through task shifting and task sharing, provide direct care to psychiatric patients [5, 6]. Interventions often must focus upon communities as a whole, rather than symptomatic individuals [18].

VI. Promoting mental health in LMIC and refugee crises often entails human rights advocacy through political activism and advocacy campaigns to protect vulnerable persons.

In many LMICs, the impact of human rights violations is so substantial that health policy initiatives, advocacy, and activism must be core elements of an effective treatment program.

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Strategy Two: Utilize Dialogue with Mental Health Colleagues from LMIC or Refugee Populations to Inform Training Objectives for US Psychiatry Residents

Educating psychiatrists for service to LMIC and other GMH populations means building trustworthy relationships with patients and clinical leaders [9]. Trustworthiness entails a commitment to dialogue and an explicit power sharing in decision-making, access to resources, and implementing clinical practices. The practice of trustworthiness seeks advisement from LMIC and other GMH colleagues for both mission and content of GMH training [9, 10, 19].

An initial draft of this manuscript was provided to GWU Palestinian clinical faculty members living and working in West Bank Palestine, site of our major departmental GMH mission. These Palestinian clinical faculties have served as supervisors and research collaborators for our West Bank GMH residency rotation. In their personal lives, they have lived with families under Israeli military occupation and have experienced security searches, checkpoints limiting traveling, and the loss of family members by imprisonment or murder during conflicts.

We asked our colleagues to provide a critique of our GMH curriculum—*Were there any additional themes, learning objectives, or training experiences that they felt should be added to the psychiatric education of American psychiatrists planning to practice or teach in West Bank Palestine? Were there any that should be dropped?*

Our Palestinian colleagues did not suggest alterations to the themes or their derivative learning objectives. Rather, they requested a shifting of priority. Whereas the "*Do no harm and adverse unintended consequences*" theme originally had been listed last, they requested that it be placed first in order of importance. They noted numerous examples from the West Bank, where the economy is reliant for social services from American and European NGOs that also unilaterally project their funders' social agendas. They commented

> We have observed that the possibilities for unintentional harm are numerous and that even with reasonable familiarity with the local culture, history, and current social/political/and economic situation, outside mental health professionals are likely to cause unintentional harm on occasion. The example that we find particularly compelling based on our own personal experience is how international donors, INGOs, international mental health professionals, and other international actors can cause harm by either deleteriously reinforcing divisions within a society or papering over meaningful divisions–in effect forcing the less powerful party within the society to compromise principles in order to obtain funding.

They provided examples in which NGO funders' agendas forced collaborations between Israelis and Palestinians that had not been preceded by building person-to-person relations upon which reconciliation could be built. They felt trapped between the need for resources and acceptance of roles felt to be integrity violations. Illustrations of dialogical practices and collaborative relationships involving other LMIC have been previously published [10, 19].

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Strategy Three: Embed GMH Learning Objectives Within Seminars and Supervisions that Can Serve Multiple Simultaneous Educational Roles in Order to Conserve Program Resources

Since its 1998 inception, our GMH program has been challenged by both insufficient funds to compensate residents' out-of-country travel and an absence of institutional global health programs to which a psychiatric component could be attached. Consequently, we prioritized the teaching of GMH skills with local immigrant and refugee populations (3). We placed GMH training objectives within seminars that also served multiple educational aims for all our residents. For example, distinguishing depression as psychopathology from demoralization as a "normal" stress response matters similarly for a medically ill patient in US hospital as for a politically oppressed villager in a LMIC (13). Table 1 lists 11 multi-purpose seminars in which learning objectives for the six themes were inserted.

Strategy Four: Provide a Global Mental Health Track for Motivated Residents Who Seek Advanced Levels of GMH Expertise

A formal Global Mental Health Track (GMH Track) was established in 2011 with specific expectations for training and scholarship. Residents in the GMH Track were provided with highly individualized programs of study reflecting each resident's aptitudes and career aspirations. Residents fulfilled the following expectations over the 4 years of residency (see www.gwupsychiatry.org for further details):

- Regular participation in monthly Global Mental Health seminars in which residents and faculty present research projects for discussion and critique;
- Completion of a scholarly project meriting presentation in a research conference or publication;
- Specific expertise regarding a selected ethnicity, country, or region of interest;
- Completion of clinical rotation in a low- or middle-income country or armed conflict zone;

And/or, acquisition of advanced expertise in psychiatric care of immigrants, refugees, and political torture survivors;

And/or, acquisition of advanced expertise in human rights advocacy and psychiatric assessment of political asylees.

Outcomes for Our GMH Program

The major measure of success for a GMH program lies in its impact upon career trajectories, professional competencies, and future contributions of its trainees. Six residents in the GMH Track since 2011 accomplished during their residencies:

- Training experiences and research projects in seven LMIC;
- Publication of 15 journal articles and one book chapter;

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- Professional recognitions that included an APA/Substance Abuse and Mental Health Services Administration (SAMHSA) Fellowship and leadership roles in the American Psychiatric Association's Council on International Psychiatry and Global Mental Health Caucus.

After graduation, a consistent long-term outcome has been commitment to human rights advocacy, with most GMH Track graduates continuing to conduct Physicians for Human Rights (PHR) psychiatric evaluations for political asylees and two graduates serving as adjunct law school faculty for immigration clinics. All six have continued to teach global mental health as full time or adjunct psychiatry faculty members. Profiles of these graduates illustrate the breadth of influence of the GMH Track upon career development:

Resident A traveled to Cambodia during her PGY-IV year to study how testimonial therapy had been employed as a community-based therapeutic ritual aiding recovery of survivors of Pol Pot genocide. She and other residents then adapted testimonial therapy for a domestic violence survivors group of Spanish-speaking women. Their project was subsequently presented at an international conference on testimonial therapy. Resident A is now a full-time GWU psychiatry faculty member who teaches the "Psychiatric Care for Immigrants and Refugees Seminar," provides PHR asylum evaluations, and is co-investigator on funded PTSD research.

Resident B utilized funding from his American Psychiatric Association/SAMHSA Fellowship to conduct program outreach that linked the GWU refugee mental health program with other regional immigrant advocacy organizations. He also produced the first mid-Atlantic regional conference of torture survivor programs. As a community psychiatrist, he currently directs mental health services at a major community health agency serving minority and immigrant populations, provides PHR asylum evaluations, and teaches immigrant and refugee mental health in our GWU psychiatry residency and school of public health.

Resident C, now a forensic psychiatrist, directs our GWU Human Rights Clinic, trains residents to conduct asylum evaluations, and conducts human trafficking forensic evaluations. She teaches in the "Global Mental Health and Cultural Psychiatry Seminar" and works with the American Psychiatric Association to implement immigrant mental health, education, and advocacy projects. She provides consultation to a low-income country's ministry of health in its revision of mental health law.

Resident D had already created an NGO that educated mental health clinicians in West Bank Palestine and Gaza prior to arrival in our GWU residency. During each PGY-I through IV residency year, resident D conducted periodic training experiences in a Bethlehem Community Mental Health Center under supervision of local psychiatrists who were appointed as GWU adjunct faculty. This arrangement enabled resident D to continue administrative leadership of his NGO, which received European grant funding for new primary care and school-based mental health programs during his PGY-IV year. Resident D now serves on our GWU GMH faculty as Director of Global Community Psychiatry Programs.

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Resident E joined our GWU residency with ongoing GMH collaborations in South Asia and Africa. During residency, resident E received grants and support from NIMH, Grand Challenges Canada initiative in GMH, and The Carter Center which enabled three PGY-III months and eight PGY-IV months in mental health services research projects in Nepal, Uganda, and Liberia. After graduation, resident E joined the faculty of a global health institute where the majority of his academic time to focus on GMH initiatives. He continues to mentor GWU GMH Track residents.

Limitations and Further Research

The four educational strategies employed by our curriculum contribute to its generalizability. However, our program is largely shaped by our local patient populations, academic faculty, and institutional resources that may limit the generalizability of its specific features. Input from the single LMIC should be compared to feedback from other LMIC and refugee populations, which might highlight other needs. Further longitudinal study of impacts of GMH training upon professional development for psychiatrists is needed for our program and others.

In conclusion, contextual, cultural, and health systems distinctions between high resource settings in North America and LMIC cultures in terms of ethnopsychologies, psychiatric diagnoses, psychiatric illness morbidity, and social suffering can guide selection of learning objectives and training experiences for a global mental health program in psychiatry residencies. Input from colleagues who are members of LMIC and refugee populations can guide selection of relevant content. We have employed both methodologies to design a Global Mental Health Track that is largely embedded within a GWU residency curriculum that provides GMH training for all residents. Additional enrichment experiences for Global Mental Health Track residents are provided through study groups, mentors, international training experiences, and professional conferences and workshops. This curriculum has proven effective not only for clinical service and research in LMIC but also for community psychiatric care of local immigrant and refugee populations. It has established GMH as a core element of our department's national identity and an impetus for residency recruitment, teaching, and scholarship.

Implications for Educators

- Distinctions between US mental health services and conditions in low- and middle-income countries and refugee populations in terms of ethnopsychologies, psychiatric diagnoses, morbidity of psychiatric illnesses, and social suffering can guide selection of learning objectives and training experiences for a global mental health curriculum.
- Dialogue with colleagues in low- and middle-income countries can further guide curricular priorities and demonstrate a commitment to collaboration, mutuality, and respect across gaps of culture and socioeconomic status.
- A global mental health curriculum can be largely implemented by embedding its learning objectives within seminars serving multiple educational roles and by supervised psychiatric care of local immigrant and refugee populations, thus

sparing programs with limited resources undue stress from investing in new curriculum.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

GMH training embedded within seminars and supervisions that serve multiple educational roles

GMH training is located within 11 seminars and clinical rotations that are required for all residents	
Theme IV	PGY-II Seminar: "Clinical Neurosciences" (ethnopharmacology, local biologies) [20]
Themes I, II, V	PGY-II Seminar: "Global Mental Health and Cultural Psychiatry" (adverse unintended consequences, ethics of alterity, dialogic practices, Cultural Formulation Interview, distress vs. disorder, category fallacy, community mental health needs assessment, task shifting/task sharing)
Theme VI	PGY-II Forensic Psychiatry Seminar (forensic evaluation of human trafficking, psychiatric evaluation of political asylees)
Theme VI	PGY-III Human Rights Clinic (at least two supervised political asylee evaluations with preparation of report)
Theme II	PGY-II Rotation: "Psychosomatic Medicine" (distinguishing normal syndromes of distress from psychiatric disorders, supervised bedside psychotherapy with interventions to counter demoralization)
Themes I, III	PGY-III/IV Seminar "Managing Stigma Effectively: Social Psychology and Social Neuroscience of Stigma" [4] (assessment/formulation/intervention to counter stigma in role as patient's advocate; when stigmatized by a patient or medical colleagues; as internalized stigma)
Theme II	PGY-III Seminar: "Resilience-Building Brief Psychotherapy with Medically-Ill Outpatients" (mobilizing assertive coping; activating common factors for therapeutic change, such as therapeutic alliance, hope, and expectancy for change)
Theme II	PGY-III Supervision: "Brief Psychotherapy Supervision" (year-long weekly supervision of resilience-building brief psychotherapy)
Theme II	PGY-II Seminar "Hope Modules: Evidence-Based Practices for Mobilizing Hope" (utilizing evidence-based practices for mobilizing hope to counter despair)
Theme III	PGY-III Seminar "Family and Systems Therapy" (family alliance-building skills; systemic assessment, formulation, and intervention)
Themes V, VI	PGY-III Health Policy Rotation (3-week full-time interdisciplinary immersion in health policy, with policy analysis and preparation of brief as final exam)
Residents who elect the Global Mental Health Track complete an additional required seminar and rotation in immigrant and refugee mental health:	
Themes I, II, IV, V	PGY-III Seminar: "Psychiatric Care for Immigrants and Refugees" (CFI interview, ethnopharmacology, trauma-informed care, ethnocultural transference, treating psychiatric sequelae of torture, interpreters)
Themes IV, V	PGY-III/IV Clinical Rotation: "Community Mental Health Services for Immigrants and Refugees" (year-long, half- or whole-day clinic with supervised treatment of immigrants and refugees from 30 or more countries)