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Has The Time Come for a Cultural Psychiatry Fellowship in the United States?

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Growing practice guidelines, research scholarship, and policy mandates suggest that the time is ripe to consider the creation of subspecialty fellowship programs in cultural psychiatry. Cultural psychiatry has been defined as “a transdisciplinary field, principally drawing from interpretive social sciences (e.g. medical anthropology), social and psychiatric epidemiology, clinical psychiatry and psychology, and the concerns of mental health professions from non-Western ethnic, diasporic, and national groups” in responding to the needs of patients from all cultural backgrounds in the United States and abroad [1]. This definition acknowledges that cultural psychiatrists draw from different disciplines to understand how to provide cross-cultural care. One set of standards to assess the prospects for initiating one-year cultural psychiatry fellowships after psychiatric residency training comes from the Accreditation Council for Graduate Medical Education (ACGME). The ACGME defines a subspecialty program as “a structured educational activity comprising a series of learning experiences” following the completion of a specialty education in an ACGME-recognized residency program [2]. These criteria, listed below verbatim, must be documented to accredit a new subspecialty [2]:

1. The clinical care and safety of patients will be improved through the recognition of the discipline;
2. The existence of a body of scientific medical knowledge underlying the subspecialty that is clinically distinct from other areas in which accreditation is already offered;

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Conflict of Interest

None.

3. The existence of a sufficiently large group of physicians who concentrate their practice in the proposed subspecialty;
4. The existence of national medical societies with a principal interest in the proposed subspecialty;
5. The regular presence in academic units and health care organizations of educational programs, research activities, and clinical services such that the subspecialty is broadly available nationally;
6. A projected number of programs sufficient to ensure that ACGME accreditation is an effective method for quality evaluation;
7. The duration of the subspecialty program is at least one year beyond education in the core specialty; and,
8. The educational program is primarily clinical.

Cultural psychiatry's professional status in the United States meets many of these criteria. First, governmental agencies, professional organizations, and researchers have consistently affirmed that clinician attention to culture improves patient care and safety. The Office of the Surgeon General, the National Institute of Mental Health (NIMH), and the Substance Abuse and Mental Health Services Administration (SAMHSA) acknowledged in 2001 that racial and ethnic minorities have less access to mental health services and quality care than Caucasians, calling for policies to train clinicians in cultural competence to alleviate disparities [3]. Moreover, cultural psychiatrists involved with revising the third through fifth editions of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* have argued that culture is central to the clinical care and safety of patients [4]. DSM-5 states that "Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis," and includes a section under most disorders titled "Culture-Related Diagnostic Issues" for diagnostic criteria when cultural variations in psychopathology have been identified [4]. Beyond access to services and diagnostic formulation, systematic reviews and meta-analyses have shown that adaptations of interventions such as psychotherapy based on patient cultural backgrounds are more effective than non-adapted interventions and that the use of interpreters improves clinician diagnostic accuracy and patient information disclosure than when interpreters are not used [5–6]. Subspecialty fellowship programs can consolidate the knowledge and skills received during psychiatric residencies in a variety of ways, such as instructing trainees on documenting symptom variations in diagnostic criteria among specific populations to learning the processes of culturally adapting psychotherapies and optimizing the use of interpreters in practice.

Second, the knowledge underlying cultural psychiatry is distinct from other subspecialties. Since the 1800s, cultural psychiatry's three research agendas include: (1) the universality or relativity of psychopathology and healing practices, (2) the provision of services to ethnically diverse populations, and (3) the cultural analysis of psychiatric theory and practice [7]. Just as psychiatry has evolved with developments in medicine and psychology, conceptions of culture have evolved with developments in the social sciences [8]. Subspecialty fellowship programs would equip trainees with the ability to learn the field. For

example, questions about the universality or relativity of psychopathology exist not just for the DSM and ICD classifications, but also for NIMH's Research Domain Criteria (RDoC) since culture situates shared meanings around the brain's responses to developmental, interpersonal, and societal environments [9]. Ethnic groups vary in response to medications, leading to practice-relevant research on therapeutic dosages and side effects based on genes, diets, and environmental influences [10]. Despite its origins in the United States during the civil rights movement of the 1960s, cultural competence has interested others abroad, and countries define acceptable treatments, the role of mental health professionals, and normal/abnormal behaviors differently [11–12]. Textbooks [13–14] and journals such as *Transcultural Psychiatry*, *Culture, Medicine, and Psychiatry*, the *International Journal of Culture and Mental Health*, and *Psychopathologie Africaine* reinforce this distinct knowledge and need for ongoing professional development.

Third, many physicians concentrate at least part of their practice in cultural psychiatry. Our personal correspondence with the American Psychiatric Association's (APA) Division of Diversity and Health Equity indicates that its Minority Fellowship Program (MFP) to train psychiatric residents in eliminating racial and health disparities has produced 692 fellows from 1973 to 2015. Based on APA statistics collected in March 2015 on Minority and Underrepresented Groups Caucuses (MURs), there were 714 psychiatrists in the Asian MUR, 652 in the International Medical Graduate MUR, 391 in the Hispanic MUR, 386 in the Black MUR, 347 in the Gay, Lesbian, and Bisexual MUR, and 51 in the American Indian MUR, totaling to 2,541 who belong to any MUR out of 36,374 psychiatrists APA members. Therefore, approximately 7% of APA members belong to a MUR, representing a substantial population of physicians with at least some interests in cultural psychiatry as professionals concerned with non-Western ethnic, diasporic, and national groups [1]. The number of psychiatrists generally active in cultural psychiatry may be higher since this figure only includes APA members. Formal fellowships may allow APA MFP participants, MFP alumni, and current MUR members to expand their base of knowledge and practice and claim expertise in cultural psychiatry. In fact, the APA has endorsed the distinctness of cultural psychiatry in a 2013 position statement, noting: "The American Psychiatric Association supports Cultural Psychiatry as a specific field of study relevant to the assessment and care of all patients" [15].

Fourth, national medical societies exist to promote cultural psychiatry. The Society for the Study of Psychiatry and Culture (SSPC) is the North American society that advances the interests of cultural psychiatry domestically and internationally as a member organization of the World Association of Cultural Psychiatry. In keeping with the field's transdisciplinary nature, many cultural psychiatrists attend conferences and contribute to journals of allied societies such as the International Association for Cross-Cultural Psychology, the Society for Medical Anthropology, the Society for Psychological Anthropology, and the Society for the Psychological Study of Culture, Ethnicity, and Race. Subspecialty fellowship programs could foster the creation of formal networks that are crucial for expanding the field. Psychiatrists interested in career advancement could find employment in behavioral health care organizations, hospital-based psychiatry-liaison services, medical and person-centered health homes, accountable care organizations, and integrated delivery systems that serve diverse patient populations. Those interested in academic work could draw upon a database

of peers whose nominations and review would be helpful in securing promotion and tenure. Patient care could also be improved as psychiatrists exchange information on best practices in relation to specific disorders, service engagement, and experience with particular populations.

Fifth, academic units and health care organizations sponsor national educational programs, research activities, and clinical services in cultural psychiatry. The ACGME/American Board of Psychiatry and Neurology (ABPN) have mandated that psychiatric trainees demonstrate knowledge of cultural issues for key residency milestones [16]. In fact, the ACGME's Clinical Learning Environment Review Program (CLER) requires residents, fellows, and faculty to be trained and engaged in health disparity reduction, cultural competence, and quality improvement initiatives [17]. The Joint Commission, responsible for accrediting and certifying American health care organizations, states that it "views effective communication, cultural competence, and patient- and family-centered care as important components of safe, quality care," outlining culture-related performance benchmarks regarding hospital admission, patient assessment and treatment, discharge and transfer, and organizational readiness [18]. In 2013, the Department of Health and Human Services released enhanced national standards for Culturally and Linguistically Appropriate Services (CLAS) to tailor health services based on patient cultural needs and preferences, with at least six states requiring or recommending CLAS-based continuing medical education for clinicians [19]. Cultural psychiatry fellowships could equip graduates with the skills essential for understanding, comparing, and implementing changes in academic, organizational, and system-wide policies related to standards for cultural competence – skills that are not a formal part of the basic curriculum in general psychiatry residencies. The need for health care organizations to comply with evolving cultural competence mandates argues for a formal credentialing process that could be addressed through cultural psychiatry fellowships.

The last three ACGME criteria on the number, duration, and clinical nature of subspecialty programs are not yet fulfilled since there are no cultural psychiatry fellowships in the United States. However, there are lessons to be drawn from history as well as geography. In the United States, the closest approximation to a cultural psychiatry fellowship was a NIMH-funded training program in clinically relevant medical anthropology at Harvard University from 1984 to 2008 for physicians and social scientists to examine relationships between culture and mental health that graduated over 70 fellows [1]. Several members of the GAP committee that gave rise to this paper participated in this fellowship and devoted part of their careers to formulating and implementing cultural competence policies in state mental health systems at a time when such policies were not mandated. A review of current programs elsewhere may also offer guidance. For example, the Canadian Psychiatric Association (CPA) has published training guidelines in cultural psychiatry based on literature reviews, program audits, and expert consensus to outline key concepts, core competencies, essential skills, pedagogical methods, and techniques for continuing professional development [20]. Although these guidelines utilize standards from the Canadian Medical Education Directions for Specialists, they could be modified for a one-year fellowship in the United States based on ACGME/ABPN standards. The American Association of Directors of Psychiatry Residency Training have also endorsed model curricula for cultural psychiatry [21]. These

examples – as well as other master’s programs and training fellowships whose content could be accessed through the World Association of Cultural Psychiatry – offer starting templates for fellowship programs in the United States.

A balanced approach to considering the possibility of establishing cultural psychiatry fellowships also anticipates objections. Some may question whether there would be sufficient interest among trainees, but the APA-SAMHSA MFP, MUR caucuses, and affiliated societies for minority and under-represented groups indicate persistent interest, especially as cultural psychiatrists have taken leadership roles to reduce behavioral health disparities over the past two decades [11]. Others may wonder whether cultural psychiatry fellowships could be subsumed under the NIMH’s new global mental health (GMH) fellowships, but these are intended to deliver and evaluate mental health interventions in resource-limited international settings [21]. The cross-cultural exposure in GMH fellowships supports long-term improvement of mental health primarily in low- and middle-income countries and only secondarily in domestic contexts [22], a goal that is valuable but nonetheless different from cultural psychiatry’s three main agendas, mentioned earlier [7]. Additionally, some may believe that the topics subsumed under cultural psychiatry should be integrated within a general psychiatric education rather than a specialty fellowship. While we would welcome increased didactic and rotation time expressly for cultural psychiatry in general psychiatry residencies, many of us who work as cultural psychiatrists appreciate organizational constraints. Like our colleagues from other psychiatric subspecialties, we struggle to convey generations of scholarship within ten to twelve hours in a four-year period. While this brief exposure may be sufficient for those with a healthy curiosity, it does not advance the clinical, scientific, policy, and research interests of an established field just as rotations in child and adolescent psychiatry during general residency may expose trainees to core issues, but not equip them to practice independently in the subspecialty.

Apart from ideological objections to establishing a subspecialty, there are also practical limitations related to funding. The CPA has proactively identified solutions to many funding limitations such as working with faculty, residents, and communities to produce curricula that are responsive to the needs of local populations being served; placing trainees in community settings that need psychiatrists in order to share the costs of salary support; and drawing upon experts beyond a single academic institution to share mentorship and didactics across institutions within a geographic community [20]. For example, state mental health systems could fund the salaries of trainees in exchange for working in service settings in need of psychiatrists. Departments of psychiatry could provide academic appointments for trainees in order to formalize accreditation and faculty didactics. Some may doubt whether fellowship graduates would have unique career pathways after investing in an additional year of training. We see a myriad of opportunities. Academic departments could support career pathways for fellowship graduates as clinical researchers interested in cultural neuroscience or health services delivery, clinician educators examining best methods in didactic training, or clinician administrators committed to faculty-wide diversity initiatives and compliance with public policy mandates [23]. Public mental health systems could also recruit fellowship graduates to take the lead in promoting local and state policies on cultural competence.

For these reasons, the authors call on SSPC, the American Association of Chairs of Departments of Psychiatry, the American Association of Directors of Psychiatric Residency Training, and the Association for Academic Psychiatry to take concrete initial steps by sponsoring symposia and workshops on the feasibility, acceptability, and utility of cultural psychiatry fellowships at future meetings. Future generations may wonder why it took the United States so long to establish such training programs given the extensive number of municipal, state, and federal policy mandates for health equity and cultural competence across all populations. If not now, when?

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