

# Editorial: Culture and Psychiatry

Both the impact of globalization as well as the local struggles for a melting pot society do not erase the cultural distinctiveness of the multiple population groups in Israel. Like no other Western country, Israeli society is a mosaic of cultural identities (1). For more than 60 years since its establishment, Israel has been absorbing immigrants, mainly Jewish, from all over the world. As a result, Israeli Jews, 75% of the country's total population, are ethnically diverse. Approximately 9% of them are immigrants from North Africa and Asia, 8% came from Europe and America, and 12% from the former Soviet Union. The latest immigrants to arrive came from Ethiopia (currently constitute approximately 1.3% of the Jewish population) (2). In addition, 18% of the Jewish population comprises second-generation Israeli Jews whose fathers were born in North Africa or Asia and 15% in Europe or America. Lastly, the third-generation Israeli Jews total 37% of the Jewish population (2). A substantial minority, 25%, of the population is non-Jewish, including Moslem, Christian, Druze and Bedouin groups, each holding their own unique beliefs and health-related practices (1, 2). It is thus obvious that such a varied human mosaic precludes a "culture-blind" mental health practice.

The definition of culture in mental health is challenging (3). Recent consensus speaks of a socially-transmitted constellation or construction which includes beliefs, attitudes, practices, ideas, values, institutions, and physical environments (3). Cultural values, e.g., expectations about context, age and gender normative behaviors and family dynamics, as well as beliefs about health and health care (4), have the potential to positively and negatively affect the mental health status and practices of members of a group, as well as to set the course and outcome of the clinical encounter when this takes place. The social and cultural contexts (gender, social class, educational level, poverty, and age role expectations, among other factors) provide meaning to what people, as well as the self, regard as being normal or abnormal. As an illustration, education is tied to modes of clinical presentation and symptom severity assessment (5), religion and spirituality may be linked to the experience of illness (6), and gender and sexual orientation are intimately connected to expectations about societal roles and may be relevant in risk assessment (7, 8).

In sum, culture is associated with the determinants of mental and behavioral disorders, it gives birth to mental health beliefs, modulates the expression of psychological distress and draws the path for help-seeking practices. For the clinic, the preceding factors are crucial for refining the identification and care of mental health distress and conditions for members of culturally diverse groups.

This special issue of *The Israel Journal of Psychiatry* is dedicated to aspects arising from the interplay between culture and psychiatry, and includes articles covering selected subjects of contemporary clinical interest. The first part refers to those situated at the intersection between the culture of certain population groups and mental health.

Youngmann, Pugachova and Zilber compared mental health service utilization patterns among immigrants from Ethiopia and the former Soviet Union and local-born Jewish Israelis. Their findings document differences in referral sources and treatment recommendations, thus highlighting the need to develop culturally-sensitive intervention programs. In the following article, Loewenthal expands the discussion of local cultural groups and reviews a series of studies on mental health status and care for Jews in the Diaspora, with particular focus on the United Kingdom.

Caspi and Klein report the effect of trauma and post-traumatic stress disorder on Bedouin Army servicemen and their family members, and document high mental health needs but low service utilization. Belmaker presents interesting longitudinal data on the practice of female circumcision among Bedouins and Jews from Ethiopia. Based on a series of studies he documents changes in traditional practices that clash with modern tenets in gender-related issues and health prescriptions. Lavy, Azaiza and Mikulincer close this section with data on attachment orientations of Arabs and Jews that account for higher attachment anxiety among the former.

Culture is an integral part of the clinical encounter. The second part of this special issue is dedicated to articles discussing subjects arising from the intersection between culture and psychiatry before and during the clinical encounter.

Topics that emerge prior to the clinical encoun-

ter refer to health disparities, defined as population-specific differences in the onset, prevalence, severity of disorder, and differential access to health care. The populations most seriously affected by adverse health disparities include ethnic minorities that often seek and receive care partially or fully affected by language and cultural barriers. The research to date on disparities in Israel has focused on health-related outcomes, with important differences found in life expectancy and illness rates as a result of cultural background, immigration history, socioeconomic status, gender, and residence area (1, 2, 9). As well, relatively recent epidemiological studies show that prevalence rates of mental health disorders are higher among Arab Israelis compared with Jewish Israelis (10), and between recent immigrants from the former Soviet Union and native Israelis (11). Consistent differences in mental health also exist between Mizrahim (primarily Jews of Asian/North African descent) and Ashkenazim (primarily Jews of European/American descent); Mizrahim are twice as likely to suffer from mood or anxiety disorders compared to Ashkenazim (12).

In many urban mental health clinics worldwide clinicians encounter a growing multicultural population. In Israel, this population includes service users with limited Hebrew proficiency, and views of mental disorders and values different from those of the caregiver. Clinicians are charged with providing culturally sensitive care (13). However, doing so is difficult, because complex information is needed to understand and be empathic to patients from a different culture (4, 14, 15).

The U.S. Surgeon General's Report on Culture, Race and Ethnicity argues that a person's culture may impact what s/he reports, what the clinician prompts the patient to report, and how the clinician interprets the information provided (16). Culture is the backdrop for the interpersonal dimension of the clinical encounter and informs the overall conceptualization of diagnostic symptoms and treatment recommendations. Culture affects psychopathology, with clinical implications that include over- or under-pathologizing of minorities (17).

Alegría, Katz, Ishikawa, et al., in the opening article of the second section, provide U.S.-based data on mechanisms contributing to the mental health disparities focusing on the way clinicians use socio-cultural information during the mental health intake. Their findings suggest that socio-cultural information is critical to engaging patients and being able to be empathic to their needs particularly with minority patients. Nakash,

Saguy and Levav propose a conceptual model to assist in identifying mechanisms contributing to the mental health disparities in the clinic. The model is based on social psychological research, with particular emphasis on processes rooted in social categorization and social power. The authors suggest that the contrasting social identities of clinicians and service users can partially account for why discordant, compared to concordant ethnic identities in clinical encounters may produce worse clinical outcomes. Abu-Baker compared the psychosocial reactions to personal losses of Palestinian families in the West Bank and in Israel. Her analyses of the themes that emerged during the clinical interventions with women of both groups highlight the complex relationship between the social and political environment created by the protracted Israeli-Palestinian conflict and the personal selves in the working through of their trauma and loss.

Although most therapies in urban mental health clinics tend to be cross-cultural, clinicians vary in the extent and the way in which they address cultural differences in the clinical encounter (18). Mental health clinicians are rarely trained in areas such as: communicating essential concepts and information for effective mental healthcare in different languages; working effectively with patients who have limited health literacy; or effectively adapting services for diverse populations.

Clinical training programs and psychiatric practice in general bring limited tools for addressing ethnocentric biases among clinicians in their practice. Not attending to this bias has resulted in cultural misunderstandings with negative effects on clinical services and financial burden. Kirmayer, et al. (19) described misunderstandings resulting in incomplete assessments, incorrect diagnoses, inadequate or inappropriate treatment, and failed treatment alliances in inpatient services. A counterargument in research has looked at a more universalistic, non-culture-specific approach as being a simpler way to assess and classify psychiatric disorders based on agreed upon symptoms (20), thereby reducing the risk of clinical and scientific confusion (21, 22). However, cross-cultural validity of diagnosis can be enhanced when indigenous categories of experience are incorporated into assessment and "normative uncertainty," distinguishing between psychiatric disorders and culturally determined responses to illness (23).

The last two papers capture some of those issues through concrete examples of culturally-competent care and training. Cwikel and Ifergane describe the services

provided in a counseling center for women in the Negev that are based on feminist treatment models, and highlight the particular needs and preferences of women seeking mental health care. Finally, Mirsky presents a model for cultural-competence training for mental health professionals that is based on both theoretical and personal-experiential exposure to cross-cultural encounters.

Notwithstanding the efforts included in this special issue, and the rich contributions of early (e.g., Palgi, 24) and contemporary researchers (Bilu, 25; Greenberg, 26, 27; and Witztum, 28), further empirical research is needed to deepen the understanding and abilities to provide culturally-adequate care for our diverse populations.

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