PROBLEMS OF FOREIGN BORN PSYCHIATRISTS

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This paper describes problems incurred by those psychiatrists practicing in the United States who were born outside of the United States of America. It describes issues related to practice, politics, and understanding of a culture alien to them. It also focuses on some of the advantages of being a foreigner in the field.
In conclusion, the paper recommends specific training to be incorporated in residency programs to address issues identified by the author.

It has been estimated that about one-third of psychiatric residents in the United States and Canada are foreign medical graduates (FMGs) and that in some public psychiatric institutions over 90 percent are FMGs. In 1970, two countries, the Phillipines and India, accounted for almost 33 percent of all FMGs in the United States graduate programs (not only those in psychiatry), and 64 percent were from all Asiatic countries combined.[1] These data indicate that FMGs represent a large segment of our medical specialists in training and that many of these FMGs are from cultures quite markedly different from that of the United States. Obviously, FMGs encounter a number of problems in making the required adaptations; however, being foreign born also has some attendant advantages. An examination of these advantages and disadvantages may help administrators to understand FMGs and to utilize them to their best advantage.

An immediate and obvious problem facing the FMGs is that of fluency and knowledge of the English language. I know of several foreign-born psychiatrists who have done very fine work in specific areas but who have had difficulty in gaining recognition largely because of communication and language problems. FMGs encounter difficulty not only with respect to the grammar of the language but also with regard to accent, colloquial use of words, and local humor—all of which play a significant role in developing any facility with a language. Knowledge of slang and colloquialisms is useful for all who adapt to a different culture but are essential if one is to make

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diagnoses based largely on verbal reports or if one is to be effective in using the verbal modes of therapy. In this regard, I am reminded of an instance told to me of a FMG interviewing a black outpatient in New York City. When the patient stated that during the past week he had seen some "cats," the interview by the FMG pursued a line of questioning as if the patient had experienced a visual hallucination when in fact the patient was merely using this expression to indicate some of his friends. The FMG was quite embarrassed when one of his American colleagues felt compelled to interrupt the interview to correct his misinterpretation. The existence of this type of problem is indicated by the fact that in some centers there are courses in American slang for FMGs.

In addition to language difficulties, there are problems associated with differences in psychiatric knowledge. FMGs must adapt to differences in diagnostic emphases, differences in the availability and trade names of psychotropics, and differences in what are regarded as the classic psychiatric texts and theories. Lin,[2] for example, notes that most developing countries give low priority to psychiatry in medical and public health programs or pay little respect to modern dynamic psychiatry and community psychiatry. Many other countries follow a much more medical-organic model of psychiatry, and verbal therapies do not receive as much emphasis as in the United States. Thus, the FMG must become familiar and comfortable with a new set of intervention techniques.

Related to this, but perhaps more difficult to learn are differences in the application of this knowledge and issues associated with this application. For example, I know firsthand that in India (and in many other foreign countries) psychiatry is much less accepted by the general public. A dramatic example of this is provided by Jilek-Aall[3] who notes that the Coast Salish Indians of Northwest Canada "appeared virtually petrified when coming for their first interview" and perceived the psychiatrist as "an overwhelming authority figure, in collusion with law-enforcement agencies, ready to lead the patient along the road of incarceration or confinement in the mental hospital." In contrast, one finds in the United States that psychiatry and psychoanalysis have a tremendous cultural influence evidenced in peoples' thinking, in their art, novels, and movies. So much is this true that patients have the expectation that a psychiatrist will be fairly knowledgeable and willing to apply not only the various dynamic theories of psychoanalysis, but also the communication techniques that have evolved from studies of communication and sociocultural processes. In addition, patients in the United States are much less inclined to regard the psychiatrist as an all-knowledgeable authority figure and will have little reluctance in telling the psychiatrist that he does not fulfill their expectations. Although native-born psychiatrists can accept this feedback and even utilize it in their therapy, many psychiatrists who have been raised in different cultures find themselves very ill at ease in this setting.

Associated with the issues of communication and therapy are an understanding of the history of a nation, its mores, its standards of behavior, and its literature. Since cultures are different, the expectations,

values, and attitudes of the therapist and the patient are also bound to be different. For example, the parental role is different, obedience toward authority and behavior toward authority are different. Sexual roles are different. In most eastern cultures sexual roles are well differentiated as compared with the west, and this is especially true with the advent of the women's liberation movement in the west. Attitudes toward sexual behavior are also different. Ultimately, the whole gamut of emotions which finally lead to human happiness, where one finds pleasure and satisfaction, are of a different nature. The foreign-born psychiatrist has to adapt to a different set of standards and values so as to avoid not translating or expecting the kind of mores or standards from his own culture to prevail for his patients from another culture. Occassionally, the FMGs find themselves torn between their native cultural values and those they must adopt if they are to be effective therapists.

In addition, the foreign-born psychiatrist also faces problems which can have a great impact, but are not specific to his practice. For example, there is the general problem of acculturation and discrimination that he may face from different state licensing boards in the United States. To illustrate: if you are a graduate of an American school, you can pass a national board examination and then become eligible for licenses in almost all the states. A foreign-born psychiatrist, on the other hand, will have to get specific licenses by passing different examinations in different states. Then there is the question of whether, because of discrimination or other factors, a majority of foreign-born psychiatrists do not get proper training or help with the problems that I have mentioned. I hardly know of a residency training program to help a psychiatrist to adapt to a new culture, or to aid his processing through licensing boards and the like. An exception is the program for foreign residents conducted by the Department of Psychiatry of Upstate Medical Center in conjunction with the New York State Department of Mental Hygiene,[4] where modifications are made in the educational approach and courses are taught in the English language skills and American culture. In most instances the foreign resident is merely taught a new system and content of psychiatry and is never exposed to all other issues I have discussed, which are so closely associated with the application of its contents.

Another problem that affects the foreign-born psychiatrist to a large extent is his inability to enter into the private practice of psychiatry, which involves not only the actual practice of psychiatry, but also a working knowledge of the business practices of the area and the business of psychiatry in particular, an area where he finds himself most alien. One example of this is that frequently, because of perceived social distance, FMGs do not provide adequate feedback to the referring physician and thus fail to develop the customary collegical relationships so essential to private practice. This distancing is often reflected in the FMGs reluctance to address his American colleagues on a first-name basis. This, in turn, creates a reciprocal distancing. Because of these problems, you will find very few foreign-born psychiatrists entering into private practice. Instead,

they place themselves within the walls of a state mental institution or a university hospital, and not outside these sheltered settings. However, even these sheltered settings have a politics of their own, and many FMGs have difficulty in grappling with an understanding of institutional politics. As a result, it is difficult for many foreign-born psychiatrists to come up in the administrative hierarchy of a university department, a state department of mental hygiene, NIMH, or whatever.

While the foreign-born psychiatrist struggles to adapt to the system of free enterprise, he is confronted at the same time with a variety of review and regulatory mechanisms to which he is unaccustomed, including PSROs, ethics committees of medical societies, Medicare and Medicaid requirements, and the like. For many foreign-born psychiatrists this is a completely novel experience. I can speak at least for a country like India which is more of a "socialist" country than the United States. Yet, even there and in many other countries which do not proclaim or utilize the private enterprise system as freely, one finds that medical practices are not regulated so much, that standard setting bodies are small in number, and that reviewing boards are few and far between. Foreign-born psychiatrists from these cultures suddenly find themselves in another culture confronted with a multitude of regulating and reviewing agencies and feel a sort of encroachment of their private rights and private domain. This makes it difficult to relate to these agencies and opens up the possibility for a variety of mistakes in dealing with them. Furthermore, some FMGs have the false impression that this intense scrutiny is directed at them soley because of their foreign-born status.

The problems that I have mentioned above lead to a variety of personal and professional difficulties for the foreign-born psychiatrist. The severity depends very much on the individual and his ability to understand and adapt. Kim[5] notes an instance where this stress of acculturation precipitated psychotic breaks in foreign-born physicians and suggests that accultured psychiatrists should help those undergoing acculturation. This appears to be a very good suggestion which probably occurs in many settings on an informal basis.

To this point, it may appear that there are only disadvantages that befall the foreign-born psychiatrist. This is not true; there are some advantages of being born abroad. First, there is a sense or aura of mystique that occurs around any stranger, which helps some patients to develop a much stronger and easier transference which can ultimately aid in conflict resolution. I personally have had experiences where my race was considered a neutral factor by patients. Both white patients, as well as black and Puerto Rican patients, could easily trust me. One does not have to face the issue of racial feelings so common in the case of a black patient being treated by a white psychiatrist or vice versa. In addition, since major contributions to the field of psychiatry, and especially to the field of psychoanalysis which is so popular in the United States, have been made mostly by foreigners, one can take advantage of the work of foreign-born colleagues and develop an aura of grandeur around one's self which can be of further use in helping

the patient. Furthermore, in Asia, and especially in India, the religions and way of life that have emerged out of the influence of Buddhism and Hinduism naturally makes one more introspective. These cultures are more inward rather than outward oriented, and this inward orientation can be of significant advantage in learning psychoanalytically oriented modalities and in exploring the unconscious. Finally, the very experience of successfully undergoing the acculturation process with its feelings of loneliness, rejection, misunderstanding, and conflict can help the foreign-born psychiatrist to understand and empathize with his patients whose psychiatric problems often lead them to feel alien in their own culture.

I hope I have given some idea for the variety of problems encountered by the foreign-born psychiatrist and hope I have prompted medical educators and administrators, especially those in large public institutions, to think about positive approaches to helping the foreign-born psychiatrists. The benefits of such efforts will undoubtedly be great and will accrue not only to the foreign-born psychiatrists, but to the patients they serve as well.

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