Interview with Professor Laurence Kirmayer: Director of Cultural Psychiatry, McGill University, Montreal, Canada

A Hankir

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Introduction

The World Journal of Medical Education and Research (WJMER) (ISSN 2052-1715) is an online publication of the Doctors Academy Group of Educational Establishments. Published on a quarterly basis, the aim of the journal is to promote academia and research amongst members of the multi-disciplinary healthcare team including doctors, dentists, scientists, and students of these specialties from around the world. The principal objective of this journal is to encourage the aforementioned, from developing countries in particular, to publish their work. The journal intends to promote the healthy transfer of knowledge, opinions and expertise between those who have the benefit of cutting edge technology and those who need to innovate within their resource constraints. It is our hope that this will help to develop medical knowledge and to provide optimal clinical care in different settings. We envisage an incessant stream of information flowing along the channels that WJMER will create and that a surfeit of ideas will be gleaned from this process. We look forward to sharing these experiences with our readers in our editions. We are honoured to welcome you to WJMER.

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I remember having a stimulating conversation with a good friend of mine, a professor of political economy who is also a consultant for the United Nations on violent radicalisation. After having travelled all over the world in his quest to fathom the political and economic determinants of extreme behaviour, he concluded that *'most of these people were just in the wrong place at the wrong time…'* All of us have been, no doubt, the victim of circumstance in one way or another (albeit the consequences perhaps are not so grave for some as they are for others). One could equally, however, argue that being in the *right* place at the *right* time would qualify as a good working definition of luck ('luck is when preparation meets opportunity' is a quote that I chanced upon and one that resonates with me). And so here I am, braving the elements in Montreal, Canada (it is -30 degrees centigrade over here and the streets are laden with snow which reaches as high as my knees in certain areas) after having met Professor Kirmayer fortuitously in a World Psychiatry Association event in the heartland of the world, the Holy Land itself. Professor Kirmayer cordially and graciously extended an invitation to present in Canada, an invitation I just couldn't refuse. I cannot help but feel how very fortunate I am to be in his presence (Professor Kirmayer exudes serenity) and to have this opportunity to interview a world authority on cultural psychiatry. Indeed, McGill University is where cultural psychiatry all began…

Ahmed Hankir (AH): Thank you for accepting my invitation to interview you for the World Journal of Medical Education and Research (WJMER). My first question is this, 'Who is Laurence Kirmayer?'
Laurence Kirmayer (LK): Well, professionally, I am James McGill Professor and Director of the Division of Social and Transcultural Psychiatry at McGill University. My work straddles both academic and clinical areas of psychiatry as I am also a staff psychiatrist at the Department of Psychiatry of the Jewish General Hospital, and a Senior Investigator at the Lady Davis Institute for Medical Research, Montreal, Canada.

AH: Could you signpost your trajectory hitherto?
LK: My educational and training background was originally in physics and mathematics and then psychology as an undergraduate at McGill University. During my undergraduate years, I began in physiological psychology but became increasingly interested in cognitive and social psychology. In my final year of medical school, also at McGill, I had the good fortune to take a seminar in ethnopsychiatry (which was essentially on work at the intersection of anthropology and psychiatry) with the medical anthropologist, Margaret Lock. This opened up a vista that was extremely exciting.

After medical school, I completed my residency in psychiatry at the University of California Davis in Sacramento, California. I was fortunate enough to meet Byron and Mary-Jo Good who were also central in a renewed engagement between medical anthropology and psychiatry initiated by the work of psychiatrist/ anthropologist Arthur Kleinman. In Sacramento, we started a reading group in culture, personality and psychopathology. This gave me a chance to explore the relevance of psychological anthropology to clinical questions during my training. We also had a chance to take part in a consultation program that worked collaboratively with local healers from different traditions.

After three years in Sacramento, I returned to Montreal for a research fellowship in 1981, and that is when I became aware that McGill had a long and illustrious tradition in what was then called *transcultural psychiatry*. I began working as a consultant in consultation-liaison psychiatry with medical patients at the Jewish General Hospital (one of the teaching hospitals affiliated with McGill) and it was clear in that work that cultural background has a powerful impact on everyone's experience of illness, and not only on psychiatric illness.

AH: What was the focus of your research activities?
LK: Initially, I focused on the problem of somatization, because it was clear that in general hospital and primary care settings much of mental illness is manifested mainly as physical symptoms i.e. ache, fatigue and other 'medically unexplained symptoms' (MUS)). My interest was in understanding how culture shaped the expression of distress and the impact this had on the recognition and treatment of common mental disorders in primary care. My clinical work in consultation-liaison and emergency psychiatry underscore the importance of physical symptoms of emotional distress across diverse cultural groups.

Over the years, I have continued to study somatization and other modes of expressing distress to understand how people think about illness and communicate their distress to others. The key questions that I wanted to answer were, 'What kinds of knowledge do people have about illness?' and 'How do their perspectives interact with healthcare systems and the other social contexts they must navigate?'

AH: Was there an experience in particular that was the most memorable in influencing your research?
LK: I had many personal and clinical experiences that convinced me of the importance of understanding the patients' point of view. One that comes to mind was an experience of my own "attributional style." One day, I was on the floor playing with my infant daughter, and I vividly recall feeling so tired that I found it hard to get up from the floor. At the time, I interpreted this fatigue as a sign of depression - though my mood was fine. I saw my family doctor who diagnosed me with asthma (which I had never had before). So it seems I was engaged in *psychologising*, rather than somatising! Because I am a psychologically oriented practitioner, it was easy for me to devise a psychological explanation for my experience of fatigue. This really drove home the point that the ways we explain symptoms depend on personality, past experience and social context. It is important, however, to say that the division between psychological symptoms and physical symptoms can be quite arbitrary. Illness affects us as whole organisms - involving our bodies, thoughts and feelings. What we focus on - and what we feel we should conceal - is influenced by culture. Indeed, the cultural shaping of illness experience is relevant to doctors across all specialties. My own clinical work in liaison psychiatry focussed on aspects of psychiatry, psychology and social sciences that are very applicable to general medical care. The psychosocial aspects of care are often recognized in dealing with common conditions like Fibromyalgia Syndrome in rheumatology or Irritable Bowel Syndrome in gastroenterology. But understanding the personal and social context of illness is essential not only for categories of medically unexplained symptoms or functional syndromes which are a large part of practice in every medical specialty but for every health

problem. We human beings are, after all, *cultural beings*. The way that we learn to see the world shapes every aspect of experience, including the ways we perceive and cope with illness and disease.

AH: What is the distinction between 'social' and 'culture'?

LK: Although there have been debates in the social sciences and psychiatry about the distinction and their relative importance, the constructs of the social and the cultural cannot be sharply distinguished - they are intimately intertwined. People who want to emphasise the importance of economics and power tend to fall into the social camp; those who focus on the role of values, knowledge and discourse, would fall into the cultural camp. But it is important to appreciate how the two are inter-dependent. Who you are - the social position you occupy and the structural forces you experience - changes if you go to a different cultural environment. Cultural values are used to justify and maintain social structural arrangements including the inequalities that make people vulnerable or sick. Even the scientific basis of medicine has a cultural element. Although we try to refine our medical practice through scientific empiricism, at any given time it is shaped by cultural ideas and practices.

AH: What is the difference between 'Eastern' and 'Western' psychiatry?

LK: The distinction between "East" and "West" is always a bit of a caricature. In fact, it usually involves people of "the West" (i.e. Europe and North America) projecting their notions onto "the East" (most of the world!) in a way that results in a kind of mirror image. The notion of the person in the West tends to be very individualistic, while in many other cultures people tend to think of themselves in more communal, familial or collectivistic terms. For example, the normal path of development in the West is for young people to become autonomous, to leave their families and set up a new household. However, in much of the world, people live their whole lives in the orbit of extended family. This is not a lack of development but a different path governed by different norms and values. Cultural psychiatry is interested in looking at these developmental trajectories more critically and more open-mindedly. Take for instance the fact that in psychiatric nosology (DSM-IV) there is a dependent personality disorder but no independent personality disorder. If you juxtapose different ways of life, we learn a lot about normal development and pathology from cultural variation. This cultural diversity is important to appreciate, not only in the context of a globalising world, but equally from a basic science point of view. Understanding culture would guide us not only to more appropriate care for the patients we see, but also toward more accurate theories of neurodevelopment in health and illness. There is an emerging field of cultural neuroscience examining this variation. I find this extremely interesting because, like many who are attracted to psychiatry, I am looking for ways to integrate all the different levels and facets of human experience. In psychiatry, there has long been an emphasis on the biopsychosocial approach, which points toward a truly holistic and person-centred approach to medicine.

AH: What is the current state of play of cultural psychiatry?

LK: Cultural psychiatry has focused on health disparities - both globally and locally, in terms of the needs of immigrants, refugees and ethnocultural minorities. At the same time, it has continued to advocate for an integrative approach to care that challenges mainstream psychiatry. In recent decades, there has been a striking *biologisation* of psychiatry, especially in the U.S., with the assumption that neuroscience is going to give us the core understanding of the aetiology and treatment of illness and disease. To a large extent that has become the dominant view and the perspectives of social science and psychology have been downplayed. But I would argue that human biology is cultural biology. The brain is the organ of culture - and we use our brains to acquire and adapt through cultural inventions like reading, mathematics and other complex social practices. Many of the problems we see in psychiatry may reflect not structural abnormalities in the brain but the consequences of learning (programming the brain) and the unhealthy environments and social relationships people must negotiate.

Take for instance panic attacks. The psychiatrist-anthropologist Devon Hinton has described a series of culture specific panic attacks that occur in Southeast patients. For example, some of the patients from Cambodia he works with may interpret the dizziness they feel on standing due to orthostatic hypotension as evidence they are about to have a stroke and then have a panic attack. A particular symptom interpretation, based on specific cultural notions of the body, leads to a vicious circle of physical symptoms, catastrophizing thoughts, anxiety, and more physical symptoms. This particular vicious circle might not occur for someone who does not have the same system of cultural ideas. On the other hand, in Anglo-American cultures a middle aged man who gets chest tightness may worry that he is having a heart attack and this too sometimes gives rise to panic attacks.

A lot of anthropological research has made it clear that the interpretation of symptoms like chest pain or discomfort differs across the cultures. The salient models come to us from popular medical knowledge, past

experience and mass media. In Turkey, chest tightness may be attributed to grief. So you can start to appreciate the major role that culture plays in all of this. We have to be open and interested in different cultures, as physicians who hope to help others. At the same time, we must be mindful of the very powerful stereotypes that lead us to over-generalize and not see the individual who is in front of us. This is the attitude of what some have called "cultural humility" – the recognition that there are many different perspectives and we need to take the time to understand the patients point of view.

AH: What are some of the advances we can look for from cultural psychiatry?

LK: A major step in recent years has been the effort to clarify how to collect and organize information about culture and context in mental health. DSM-5 (the recent revision of the diagnostic system of the American Psychiatric Association) introduces a Cultural Formulation Interview. This is a basic approach to exploring the social and cultural context and meaning of illness. It should be part of the toolkit of every physician.

When I was a medical student one of the challenges in medicine was learning how to address sexuality. Some effort went into teaching us how to take a sexual history and becoming comfortable addressing issue of sexual dysfunction, sexual orientation and related aspects of identity and experience. Nowadays, I think one of the areas that has become especially challenging is addressing religion and spirituality. This is largely because of the geopolitical situation that has saturated us with images and stereotypes of "the Other" usually depicted as someone of very different religious or cultural background. Just as with addressing sexuality, a lot depends on our ability to develop a certain maturity, openness and ability to empathize with others to understand and address their concerns.

Cultural psychiatry also has the potential to help us rethink the notion of health and healing in medical care. In the 1970s, Miriam Siegler and Humphrey Osmond (the person who coined the word psychedelic) wrote a book about Aesculapian authority, the kind of authority that doctors or healers are given in society. In addition to the technical aspects of biomedicine based in biology, we need to understand where our social authority and psychological influence comes from. Although we seek to ground our practice in scientific evidence, in most cultures, healers draw their power and authority from some connection to religion or spirituality. Perhaps the most elementary system of medicine is shamanism. For the shaman there was no medical schools, no diploma to warrant his expertise. Instead, the shaman's authority stems from his or her own experience of illness—what Jung called the archetype of the "wounded-healer". There is some basic emotional logic behind this notion of authority. This is why we have self-help groups and this primordial level still lies underneath all of what we do in biomedicine. So, as a physician, coming to terms with one's own vulnerability, and using it to help understand the predicaments of our patients can provide an important path to empathy and a way to mobilize their own capacities to heal.

All medical intervention has psychological and social dimensions that contribute to the effectiveness of healing. The healer has to be open to the healer in the patient. It is not the healer who has the absolute the power. We need to encourage the patient to be active rather than passive. This view of the cultural and psychological dynamics of healing gives us another way to look at our medical institutions and ways of practice. It encourages us treat patients with great respect and appreciate many of the indignities they endure. Hopefully, it will lead us to re-examine our larger culture. By thinking through the conditions for psychological healing and wellness, physicians can contribute to making our medical institutions more hospitable and effective. The recognition of cultural diversity in health care is one key dimension of this hospitality and duty to care. It is also a way to contribute to building pluralistic societies that are inclusive. But this will require changes in our own attitudes toward others, to move beyond stereotypes, and understand others on their own terms. In fact, we must be advocates and agents of cultural change in the broader society, if we want things to get better for our patients.

AH: Professor Kirmayer, thank you once again for accepting my invitation to interview you.

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