Reconsideration of the Training of Psychiatrists and Mental Health Professionals: Helping to Make Soup

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For many years, we have known of deficits in our system of training mental health professionals, particularly in recognizing and integrating diversity. Recently, we have begun to understand that our literature must more authentically reflect the experiences of all people that we serve. The current paper suggests that a comprehensive biopsychosocial conceptualization of normal and abnormal behavior for all individuals is necessary to truly begin to reduce mental health disparities. The authors argue that factors such as racial, ethnic and cultural differences must be integrated into research before the literature will begin to change in a fashion that is beneficial to the mental health training process.

Key words: education ■ diversity ■ mental health training ■ pathology ■ psychiatry

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As a reflection of the larger American society, many educational and academic centers and programs that provide basic instruction to psychiatrists and other mental health professionals have historically served majority populations with majority clinicians.[1] As a consequence, models of education and training consistently produce clinicians and scientists who are well trained and skilled to serve majority populations. These models could, optimally, prepare mental health professionals to recognize, appreciate and then integrate diversity into clinical practice, research and consulting. Instead, through passive acceptance of the status quo, these models of psychiatric training default to racial and cultural insensitivity. The ultimate product of the status quo over many years is the maturation of a mental healthcare system that works poorly for many minorities and a scientific literature that is deficient in the conceptualization and treatment of non-major populations.

Although deficiencies and opportunities for growth and development in the current models of mental health education and training have been known for many years, positive change towards the inclusion of diversity has come as an evolution rather than at the pace of our growing and constantly changing society.[2] More specifically, while our American society has grown increasingly diverse over the past few decades, our understanding of fundamental psychiatric constructs such as "normality" and "pathology" have remained relatively stagnant and limited to and based upon acceptable majority population behaviors and standards for interaction. This is due, in part, to intellectual deficits in the scientific literature, a literature that notably serves as the basis of the conceptualization of human behavior and experience and on which we all were trained. These basic tools of education, training, clinical practice and scientific inquiry are too often absent from the representations of diversity that allow for a coherent understanding and subsequent integration of

the real-world experiences of diverse populations.

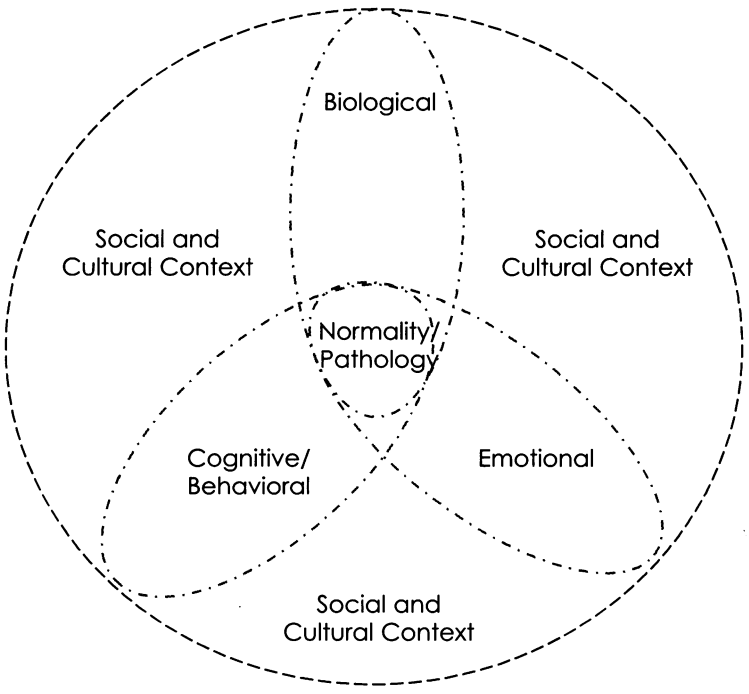
For example, we recognize that most pathology, including psychiatric illnesses, is the cumulative result of interactions among biological, psychological/behavioral, social and cultural systems (Figure 1). Traditional training in psychiatry and mental health has usually focused on one or two of these components but rarely all in combination. We have too frequently made assumptions of homogeneity and equality in the access to, experiences within and outcomes associated with the psychiatric system for all American populations. When we acknowledged differences, we have often done so in a manner that minimizes relevant factors as a function of race, ethnicity and culture that promote disparities. Ultimately, we interpreted biological and behavioral data from diverse groups in the absence of a functional appreciation of their social (racism, discrimination, inequity, etc.)[3] and psychological (high-effort coping, etc.) contexts.[4-6] Concepts recently introduced to health professionals, such as cultural competence—too often a single three-hour CME on abstract concepts that only emphasize the need to acquire more training in issues of diversity without a clear motive or a path to do so—have promoted the illusion that we are doing all that we can and should change our standards of thinking and practice to facilitate the inclusion of all who seek our services.

As our society diversifies and the number of people who do not adequately fit into our traditional conceptualizations of behavior increases, new models of human behavior that integrate both unique and common factors into the explanation of behavior become critical. Reconceptualizing the incorrect representation of the United States as a "melting pot," where individuality is lost towards the establishments of a new combined society, is a necessity. Moving to models that emphasize the representation of the United States as a "soup," where individuality is not lost but only shared towards a more appropriate conceptualization of human behavior, normality and pathology across cultures, races, ethnicities and other demographic characteristics in a manner that integrates multiple social contexts into historical psychiatric data, is likely to lead to a more functional "psychiatry" and medical system for all.

As authors, we acknowledge that the Accreditation Counsel for Graduate Medical Education (ACGME), an organization whose purpose is to accredit medical training programs within the United States, and the American Psychiatric Association (APA) have embraced a biopsychosociocultural model of educating psychiatrists since the early 1990s. Despite financial expenditures, increasing effort and time, only limited research and evidence have been generated within psychiatry to validate these models.[1] Although in their infancy, other disciplines, including nursing, social work and psychology, have moved substantively toward implementing and validating diverse models and training and practice.

Given even our limited knowledge of ethnic disparities in patterns of diagnosing psychopathology,[7] the failure of many psychiatrists and diagnosing mental health professionals to embrace new models of diversity in training as "necessary" rather than "optional" for competent practice can be interpreted in many ways. Interpretations include that the premise is: 1) too controversial and represents a "risky" shift from current standards of practice; 2) too difficult to understand and cumbersome to integrate into practice; or 3) not a logical extension of the foundational psychiatric education, training and skills that clinicians, researchers and others receive related to diversity. The authors of the current paper conceptualize this seeming resistance to embrace diversity in education and training as likely a combination of all three explanations but saliently a failure to have knowledge of populations other than the majority. That is to say that a literature that is absent relevant representations of nonmajority populations promotes inequity and bias, disparities in care and outcomes. This further implies that the mainstream of psychiatry is focused on providing care to every patient in the most appropriate way, using the very best technology and knowledge

Figure 1. Biopsychosocial Model of Normality and Pathology



available. However, our "very best" can still be insufficient to reduce disparities for disenfranchised, minority and culturally different populations.

Somewhat troubling, the authors also recognize that a small minority of psychiatrics and other mental health professionals will incorrectly view embracing and integrating the diverse experiences of multiple populations as an effort to develop multiple standards of "normality" towards the goal of separatism and regressive policies. Further, that to embrace, as the standard of care, a science that is tailored to specific subpopulations somehow diminishes our ability to effectively serve all populations. To the contrary, we posit that the concept of a relative normality applied to the science of psychiatry promotes unity by acknowledging, defining and then integrating into standards of training and practice experientially based differences of diverse people and multiple norms. Better understanding the lives of all people can only lead to more valid and reliable literature and, thus, better trained psychiatric clinicians and researchers.

For too long, we have assumed behavior to be the linear product of univariate factors. In truth, life is multivariate and complex, and occurs simultaneously in the context of multiple biological, psychological, social and cultural influences. The authors suggest that the psychiatric literature that serves as the foundation of current medical and graduate school training in mental health can lead to incorrect conceptualizations of the behaviors of racial, ethnic and culturally diverse populations. Too many researchers and clinicians have been trained to conceptualize "normal" mental health functioning as simply the reflection of how closely or far an individual or population behavior deviates from the majority. We must move towards a system where we begin to understand that normality is relative and occurs within a context that is adaptive or maladaptive often based on an environment and individual-level factors.

It is the societal responsibility of educational institutions to appropriately train the psychiatrists, psychologists, nurses, social workers and other mental health professionals of tomorrow, and to assist them to recognize and integrate racial, ethnic and cultural diversity into the practice of psychiatry. Promoting a multivariate science and training experience based on a conceptualization of normality and pathology that integrates biological, cognitive and affective factors in a social and cultural context is an essential beginning.[8] For example, moving from the traditional univariate models of psychotropic prescribing towards a multivariate and more ecologically valid model based on an understanding that pharmacodynamics and pharmacokinetics vary as a function of race and ethnicity may increase our effectiveness with nonmajority populations and may ultimately reduce health disparities in psychiatric outcomes. Combined with both new advances in psychopharmacology and increases in the number of nonmajority Americans using psychotropic medication, it is important that future generations of prescribers are adequately trained to appreciate and integrate subpopulation-level variance in response to psychotropics.

We believe that multivariate training models that integrate diversity will likely yield an increase in the number of seasoned and new clinicians and researchers who can begin to populate the literature with studies that correct deficits in our understanding of human functioning. We believe that it is the responsibility of current mental health professionals to demand such models. A paradigmatic shift in psychiatric theory, training and practice towards a "soup" and away from an amalgam that is the result of a melting pot may contribute to our continued existence as providers of an essential mental health service to all populations.

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