THE PROBLEMS OF INDIAN PSYCHIATRISTS IN AN ALIEN CULTURE

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Since the early 60's, consequent to the change in the immigration laws of the United States (USA), the number of physicians entering the United States has steadily increased. In fact, from 1957 to 1965 the number of foreign medical graduates (FMG) coming to USA fluctuated at around 2,000 a year. The rise in their number began in 1966. More than 7,000 immigrant visas went to physicians in 1972 and in 1973. Around the year 1973, there were 31,743 physicians from Asia (Stevens et al., 1975) which include a considerable number of immigrants from India. Some of these physicians have chosen Psychiatry as their speciality. The 1973 membership directory of the American Psychiatric Association lists about 220 South Asian psychiatrists from Bangladesh, Ceylon, India and Pakistan. During the year 1970, there were a total of 130 (117 male and 13 female) Indian psychiatrists among a total of 3,379 foreign psychiatrists. (Arnhoff and Kurabar, 1973). Therefore, in order to facilitate adaptation and help assimilation of the Indian psychiatrists coming to another culture and thereby assure quality psychiatric care to the population, the problems of adaptation of a psychiatrist to an alien culture is worth further investigation.

DESCRIPTION OF THE INDIAN POPULATION

The East Indian population is generally lumped as a culture group. However, India with a population of over 500 million and about one third the size of Canada, is a land of cultural and linguistic diversity, and the psychiatrists from this country are a diverse group (Sata, 1977). Therefore, the Indian immigrants cannot readily communicate with one another except in English and that they can identify with the designation of Indian psychiatrists only for the matter of convenience. They speak various languages which include Hindi, Gujarati, Marathi and Punjabi, Tamil, Telugu and Kanada as well as Arabic languages and there are a number of subtle cultural differences. Mostly, they communicate with each other in English and as they do not already have a group of people to identify with in U.S.A., they usually form a subgroup and identify with their own people around.

THE EQUIPMENT WITH WHICH THEY ARRIVE

Long ago Erickson (1963) described that the personality develops in various stages and the society provides the milieu so that each stage is successively solved to fulfill the needs of the society. Therefore, it is not surprising that the Indian society provides certain means to its people so that the personality that is most congenial for that society is developed. India is a stable society and the foundation for stability is in every family. As a long period of dependence on parents is encouraged, children are expected to look after the parents subsequently. In the family, decisions are made by the parents and competitiveness and initiative are discouraged. There is a congenial atmosphere within the family where the emotions are shared and the responsibilities are freely accepted. The ego strength of the person is pooled with that of others so that the family's strength becomes more important than that of the individual. In general then, with this

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development, the person seems passive even though he is capable of achieving. The person looks for directions from the superiors and the parents even though he can move on his own. The person limits his functioning to certain areas which have been allocated to him. This may create conflict in the new society as initiative and originality are much appreciated in the North American Continent. In addition, stability which the person seeks does not foster dynamism. Dynamic growth is prestiged in North American society and thus the assets of the personality of an Indian immigrant becomes a liability in the new society.

India is an ancient country with a well developed value and norms. The society is hierarchically organized and the territory of functioning of each role is well described. This provides a framework for an adolescent to develop without having difficulties. Such stable values and norms keep a peaceful, and emotionally secure environment. Exhuberant emotional expression is not generally accepted in an Indian society. It does not mean that the person should not feel happy but the feeling should lead to contentment rather than excitement. The person from India depends on his family to make decisions. Based on his cultural norm, even in a new society, he may look upon others for helping him to make decisions. The Hinduism is the religion of most Indians. The people believe in multiple gods, in fate, and in reincarnation. Fatalistic attitude assists people to accept their limitations and decrease omnipotence. Consequently, it also helps to decrease competitiveness and assist in converging on a goal set by the society.

Acceptance of sexual or aggressive feelings is very difficult for an Indian. Expression of aggression is tabooed and is considered a non-elite behaviour as this can upset stability which is valued very highly. Sexual repression is encouraged. Premarital sex is not allowed and expression of sexual feelings is a complete taboo. A person coming from such a family may feel uncomfortable in a society where the sexual expressions are more open or may feel scared by his own sexual feelings which can now be freely expressed in the new society. In addition, he may be even less equipped to express his own emotions even though he is allowed to do so. Lastly, the social skills necessary for courtship may be completely lacking. All these may create difficulty in dealing with sexual problems or aggressive feelings in psychotherapy.

The conceptualizations about disease have very important social implications. The definition of a disease is a product of historically determined social happenings. In India, because of the need to control infectious diseases, tuberculosis, and malnutrition, mental illness is not given priority. Again, among mental illnesses, certain symptoms like anxiety and depression are not the passports for treatment. The person who suffers from anxiety or mild depression is considered responsible for his sickness and has to find his own way out. The patients generally come to treatment with the magical belief that the doctors would cure all their illnesses. At the same time, the patients will be reluctant to discuss their difficulties with the belief that they have to find solutions for their problems (Ananth, 1976). With these cultural attitudes, an Indian doctor may develop a therapeutic relationship making the patient dependent on him and use this dependency to treat the patient (Neki, 1976) rather than to discuss and allow the patient to find his own solution. Even though such relationships can be beneficial in some cases, it conflicts with the current psychotherapeutic trends. In addition, some of the patients that an Indian physician treats may not fit into his disease concept and he may wonder why these patients ever seek treatment. These may pose some difficulty in therapeutic situations (Fabrega, 1972).
The person coming from India also brings certain aspects of the culture which may be of use in the new country. Akin to the way the older people are looked after in their own society and as a result of the interdependence of the family members, geriatric patients may be better looked after by Indian psychiatrists. The importance of families and their interrelationships in their own culture may be very useful in family therapy situations. Patients who develop a dependent relationship can be better treated on an Indian model. In addition, because materialistic attitude is discarded in Indian philosophy, certain existential neuroses can be effectively treated by Indian psychiatrists.

PROBLEMS THEY FACE IN THE AMERICAN CULTURE

Leaving the country and coming to a new country is a very difficult process. They come with certain idealism and high hopes. The aspirations of achieving for the sake of the family, of amassing wealth and knowledge and of becoming an elite psychiatrist are common. Even then, most of the people who come are sojourners. They come with a distant hope that they will return back with a fulfilled life. Their hope that they will return back to their own country sooner or later prevents learning. In addition, many people who come will have a financial burden of repaying the loans they have incurred while they were continuing their medical education and also the expenses of travelling to America. The financial burden on one side, separation anxiety on the other side coupled with the difficulty of accepting the new norms, may add to the initial difficulty in learning. Subsequently, as years advance, they re-evaluate and assimilate the new knowledge to the extent that it is useful.

During training, many of the FMG’s fail in their examinations (Brandt et al., 1975; Brody et al., 1971; Char 1971; Kleinman et al., 1975; Knoff et al., 1976; Lewis, 1970; Lewis and Lehmann, 1970; Lin, 1971; McDermott and Maretzki, 1975; Miller et al., 1973) which has been interpreted as an inferiority of the foreign medical graduates (FMG) in comparison with the local graduates. However, one should realize that a FMG is beset with multiple problems: (1) Separation anxiety; (2) a dual value system; (3) personality organization not congenial to the new culture; (4) difficulty in communication; and (5) a different set of priorities. In addition, the FMG is equipped with certain areas of hypertrophic knowledge and certain areas of deficient knowledge. Such a lopsided learning is necessary for the medical care in his own community. Therefore, even though quite competent in his own country, he is poorly equipped to succeed in the examinations in a new country. When he fails, he is considered useless which deflates his ego.

Additional problems are created by the host country. While the host country sympathizes with the FMG and provides him a job to fill the needs of its own society, he is considered not equal and his training is often in the areas that just fit the service needs. While it is written by many that the training of FMG’s has to be improved, it is still customary that the foreign medical graduate fills the positions in state hospitals where the training is not adequate. In addition, his own initiative to improve his deficiencies and to learn areas of his interest are curtailed by not providing him the rotations of his choice which may lead to further frustration, suspicion and hostility towards the new culture. The FMG is at best an ambivalently valued object. In the new culture, he is frequently asked when he would return back to his own country. In addition, the physician’s wife and children would have a lot of difficulty accepting, understanding and accommodating to the new culture. Their interactions...
with the outside world would be minimal and their unhappiness would affect the physician. The host culture in some instances shows overt rejection. Their attitude towards him is that being a foreigner he should be thankful to be living and working in America. In other cases, there is a subtle rejection. In these programmes, he is given easy assignments and not enough time and effort are put into his training. He is pushed along in the programme without much concern as to how well he is being trained in Psychiatry. In others there is an element of a denial of reality. Some programmes pretend that a FMG is like any other resident overlooking the fact that he has deficiencies and problems which are related to his foreign studies. Unrealistically, he is expected to perform on the same level as the American student resident but no special provisions are made for his shortcomings (Char, 1971). These problems that occur in his training pose difficulties for successful adaptation.

PROBLEMS OF ADAPTATION

In the new country the FMG faces a crisis situation. The resolution of this crisis may bring either reintegration at a higher level or difficulties which are lifelong. Generally, the physicians who have completed their training and who have the energy and resources to travel to a new country and to face the situations must have enough ego-strength and assets to survive in the new culture. Acculturation is a slow process. During the process of adaptation to a new culture, certain difficulties arise in interpersonal, sociocultural and psychotherapeutic areas.

Communication: Skills in verbal and nonverbal communication are vital parts of psychiatric interview and psychotherapy. Fortunately, as Indian doctors are trained in English, language barrier is not restrictive in reading or conversing intelligently with colleagues at a scientific conceptual level; yet the non-technical vocabulary needed for social conversation and refined language needed for emotional expression may not be sufficient for psycho-therapeutic intervention. In addition, the vocabulary for expressing tabooed areas such as sex is quite inadequate. An Indian doctor who is well read may not admit this deficiency either because of pride, lack of awareness or may repress because of emotional turmoil. Courses in language as a remedial measure are not very beneficial as social language is learned in the course of social interaction and its meaning understood in a social context. The physician obtains the opportunity to show his social skills and use social language during his internship where he works as a first-line man in the treatment of patients and initiate social conversation with nurses and other co-workers. Over the course of two to four years, he will gradually acquire the skill in social language to a degree that he feels comfortable. Receiving and reciprocating nonverbal messages, including expression of emotions, is an important facet of communication. East Indians do not express their emotions exuberantly on their faces or use superlatives in appreciating in a way understandable for the American population. This may be interpreted as lack of interest or as difficulty in understanding what goes on and may create difficulty in initial stages of psychotherapy. Therefore initially questions like, “You do not seem happy”; “You are a man of depth” are common. Patients on the other hand may say, “Maybe you do not understand my problem”; “You do not seem interested”; “Do you think you can help me?” Very soon, within four visits, these change.

Role behaviour: Role of a psychiatrist varies from culture to culture. In India, the physician is very highly placed and the expectations of the patients of what he can do are idealistic and not realistic. His behaviour to meet the assigned role is to
assume omnipotence, establish a dominant-dependent relationship and assert his authoritarian role. This creates difficulties in the new culture where he finds it difficult to be democratic and less authoritarian. In fact, expectations of patients of what a psychiatrist can do itself is different which may produce perplexity.

Family problems: While the male psychiatrist is pushed towards integration into the new culture, there is a countercurrent of subtle pull towards traditional values by his family. The isolated wife fears that a change in him may be alienation and exerts subtle influences to keep the tradition. In many instances, the wife's unhappiness may come in the way of his adaptation. A female psychiatrist, finds it more difficult to adjust as a change in body image, values or traditions are unacceptable to her superego.

Sociocultural problems: The values and customs of Indians are dissimilar to those of North Americans. The dissimilarity of Indians is striking and quite often creates difficulty. Sari-clad or a turban-wearing psychiatrist feels within herself or himself a feeling of being different not with pride but with self-consciousness. The vegetarianism, eating with fingers, and not drinking alcohol are socially viewed contemptuously making him feel self-doubt, inadequacy and anxiety. In addition, his distinct physical characteristics make it difficult for him to identify with any of the existing ethnic groups. Therefore, he starts feeling that his uniqueness is a weakness. He may become sensitive to comments and criticisms.

Psychosocial: When he is in the new country, he loses the nurturing family living and finds with dismay that dependence is a taboo (Neki, 1976). In addition, when working he learn that whatever he knows is useless and only what he doesn't know is useful which may threaten his self-direction and ego-identity. While this threat may be useful in some in that it helps in a new organization and it is disrupting in others.

Religion: Quite often patients ask the doctor, "Are you a Roman Catholic?" Religion as an institution carries a number of values and norms. Hinduism is non-dogmatic and has no particular set of rules. The religion is a way of life for Hindus. Therefore, a practising Hindu never thinks of religion apart from his life whereas Christianity is fairly organized. An extremely guilty Christian may find it very difficult to understand a Hindu accepting the problems as God-willed. In a psychotherapeutic relationship the religion will create problems in some circumstances.

INTEGRATION

The adaptation process starts on the day the person comes in. The separation anxiety, the cognitive dissonance the person feels and the cultural problems as well as the reality that confronts him become the strength for progress. In the beginning, it is natural for him to fall back on his old values and glorify the past with a contempt for the present. This stage may create some bitterness among his friends who cannot understand his resentment of the new culture in which he wants to settle. This stage is only temporary, as these defences do not help him to adapt. Soon he learns that his stay in the new country is a reality and begins to reevaluate the value systems of both countries. At this point, he has to renounce many of his past ideals which is very painful for the superego, leading to anxieties, depressions and gradually assimilate some of the new ones. When he integrates the values of the old culture with those of the new culture, he emerges as an integrated psychiatrist who is more mature and better integrated than some of his colleagues. The new integration makes him better equipped to deal with the problems. He can see the cultural differences and understand the uniqueness of the human
being. He can alter the structure of the personality through psychotherapeutic process more incisively because of the personal experiences he has gone through. In addition, he can make a unique contribution, one that cannot be made by others who have not had a similar experience. He has with him a certain set of norms and values from both cultures that are extremely useful to the new society. Thus, he can open up new vistas in psychotherapy, in psychiatry as well as in other areas of the new society. Contentment and the respect for the family and the attitude towards aged people are some of the concepts an Indian psychiatrist can use with advantage in the new society. In addition, scientifically, because of contentment and not competitiveness, he can evaluate rationally. He can bring new dimensions by objectively studying subjects like yoga about which he may have a better knowledge. Finally, the stability of family and relationships being so different in two countries, an Indian psychiatrist has a unique opportunity to evaluate, assimilate and redefine these problems and find solutions. In psychotherapy, Western society emphasizes the doctors and patients must not only have a common idiom to describe the subjective illness of neurotic nature, but also must agree upon a specific paradigm for the psychotherapeutic patient relationship. As this relationship in the Western society progresses from a magical, then a dependent and finally to a realistic relationship, dependency longings are considered a sign of morbidity and thus become a focus of psychotherapy. In the Indian environment, the ideal of maturity is a satisfying and continuous dependency relationship (Surya, 1966). The psychotherapeutic relationship and methods which are contributed by Indian thinking are unique and different (Neki, 1973; Pande, 1938). In Western society, many patients who have dependency characteristics and patients who have difficulty in developing the particular relationship have been coded as incorrigible patients for psychotherapy. The Indian psychiatrists have an opportunity to provide a new form of therapy using Indian methods and improve the psychotherapeutic technique in treating patients who are not accessible for the usual forms of psychotherapy.

Indian psychiatrists encounter many problems. In the course of three to five years they catch up, reintegrate often at a higher level. Because of their unique experiences in both cultures, and because of their ability to adapt to both cultures, they will be in a position to contribute something new to the culture they have adopted. I think, the new culture for tolerating the process of their growth can harvest by encouraging the Indian psychiatrists to bring some of their own values which may be useful to the new culture to the focus of research and further work.

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