Culture, Ethnicity, and Mental Health

For some fifteen years now, I have been practicing in a field that I have loosely termed "political psychiatry." Perhaps I should say that originally it was loosely termed, because over the years, working and dealing in Washington where sometimes the lines between politics and psychiatry are very sharp, other times somewhat vague, I have found the meaning of political psychiatry much more concrete. In recent years particularly, the body politic—especially the executive and legislative branches, but also the courts and the states and the interest groups—has taken an increasingly dominant role in forging and tempering the mental-health system. My involvement has entailed monitoring and directing the necessary dynamics, attempting to make them reciprocally advantageous to the parties directly involved, while always keeping foremost in mind the needs and concerns of the taxpaying citizen.

Mental health today suggests a broad social phenomenon that truly encompasses concerns extending from the cellular and biochemical levels to the family and neighborhood and community and political levels. In addressing these concerns, one is expected to deal with such basic questions as how mentally healthy are the nation and the world, and how may they be made more so?

Obviously, any movement this broad is bound to benefit as well as to suffer from the diversity of opinions that are generated by its definition and practice. The best strategy lies in at least appreciating and, better yet, understanding the diversity and then attempting to deal with the differences.

In this light, a discussion of ethnicity and culture and mental health highlights the range, the diversity, and sometimes the polarity of the issues we are dealing with. Various conflicts and dimensions familiar to those of us working in mental health take on a special significance when viewed through the lens of ethnicity. They have to do essentially with definition and practice. Perhaps we should ask ourselves how different our discussion would be if it concentrated on health or social services. Heart disease or cancer may be defined in Australia or

Bertram S. Brown, M.D., is Director of the National Institute of Mental Health, Department of Health, Education, and Welfare.

This paper is the substance of an address given at the Conference on Culture and Ethnicity—Mental Health Services for a Pluralistic Society held under the sponsorship of the Institute on Pluralism and Group Identity, American Jewish Committee of New York, and the Maurice Falk Medical Fund of Pittsburgh, at the University of Pittsburgh School of Medicine, Department of Psychiatry, on October 13, 1976.
Africa, in a way that is likely to be workable for the clinician in the United States or Asia. We know this not to be necessarily so for problems of mental illness and health.

Does a pediatrician, a surgeon, a gerontologist require special training to be sensitive to or informed about culture and ethnicity? Obviously, a sensitive professional dealing with patients as persons will be aware of these differences. Still, the clinical symptoms are likely to be more or less uniform. The differences that do exist will probably fall within the psychosocial dimensions of medicine—the differential perception of a response to pain, for example, of Jews, Italians, Irish. These questions provide interesting approaches to the ethnicity and culture issue, to see what is special about mental health.

I shall briefly describe some of our recent efforts to find out what is common to and what is unique about mental illness and health in various locations and cultures in this country and the world, for I believe that seeing some of the scientific issues and questions in that sphere will help illustrate some other questions that may apply more directly to a national perspective on mental-health services for ethnic groups in the United States.

**A global view**

My job calls for a lot of world travel. In fact, I shall soon be returning to Moscow to renegotiate the U.S.-U.S.S.R. agreement on health and science, of which the most controversial component, as one might imagine, is psychiatry. With regard to political sensitivity this particular issue of health and science in détente perhaps comes closer to concerns over ethnicity than does any other. These world travel assignments on behalf of mental health do provide very special perspectives. An anecdote may provide some feeling for this international viewpoint.

Two years ago, on this same errand, negotiation of the U.S.-Soviet health and science agreement, I traveled directly from Moscow to the Vatican to visit with His Holiness, the Pope. At the beginning of our long and intensive interview, I learned a lesson in the power of ethnicity when I found myself, to my surprise, unconsciously motivated to open our dialogue by greeting him in Yiddish!

In this framework, let me go back to the international perspective on mental illness and health.

I shall start with a seemingly easy question: Is schizophrenia the same disorder when it is encountered in the United States as it is in Western Europe, Eastern Europe, India, or elsewhere in the Orient? We are talking about a diagnostic category that has been with us for roughly one hundred years now, about a disorder that accounts for approximately 25 percent of the 2.7 million patients seen annually in the organized mental-health care system in this country. The significance of this disorder as a public-health problem cannot be underestimated. Within the research establishment it has not been underestimated. The question I just asked has engaged the attention of many of our most talented investigators over the years.

Because schizophrenia appears to exact a similarly high toll of disability in