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Teaching in cultural psychiatry: towards a decolonial attitude.

Ensino em psiquiatria cultural: rumo a uma atitude decolonial

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ABSTRACT

Introduction: This essay is based on the teaching experience of theTranscultural Psychiatry Program at the University of São Paulo (ProSol,Programa de Psiquiatria Transcultural da Universidade de São Paulo) and on theoretical foundations in the field of cultural psychiatry.

Objective: To highlight the importance of teaching cultural psychiatry for the training of psychiatry residents.

Results: Brazilian psychiatry, throughout its history, was marked by the incorporation of knowledge from developed countries with little concern for the Brazilian reality. The teaching of cultural aspects, in the psychiatric field, makes it possible to reactivate the importance of Brazilian reality and specificity for the teaching of residents.

Conclusion: The central thesis of this essay is that the teaching of cultural psychiatry is a form of decolonization of teaching, insofar as it makes psychiatrists more apt to face the different clinical scenarios in a diverse country full of contradictions such as Brazil.

Key-words: Psychiatry; Cultural Competency; Internship and Residency.

RESUMO

Introdução: *O presente ensaio é baseado na experiência de ensino do Programa de Psiquiatria Social e Cultural da Universidade de São Paulo (ProSol) e em fundamentações teóricas do campo da psiquiatria cultural.*

Desenvolvimento: *Neste ensaio, destaca-se a importância do ensino em psiquiatria cultural para a formação de residentes na psiquiatria. A psiquiatria brasileira, ao longo de sua história, ficou marcada pela absorção dos conhecimentos advindos dos países desenvolvidos com pouca preocupação com a realidade brasileira. O ensino dos aspectos culturais, dentro da psiquiatria, possibilita reativar a importância da realidade e especificidade brasileiras para o ensino dos residentes.*

Conclusão: *A tese central deste ensaio é que o ensino de psiquiatria cultural é uma forma de decolonização do ensino, na medida em que torna os psiquiatras mais aptos para enfrentar os vários cenários clínicos de um país diverso e cheio de contradições como o Brasil.*

Palavras-chave: *Psiquiatria; Psiquiatria Cultural; Internato e Residência.*

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INTRODUCTION

This essay is the result of the teaching practice of the Transcultural Psychiatry Program at the University of São Paulo (ProSol, *Programa de Psiquiatria Cultural e Social da Universidade de São Paulo*). It is a training service for residents, created in 1997, to promote the development of skills and theoretical foundation on cultural aspects of psychiatry. ProSol assistance services are specialized in populations whose challenges of cultural encounter are moreprominent: people with auditory disability, indigenous people, immigrants, refugees and asylum seekers.

Cultural - or transcultural - psychiatry has a great interface with social and human sciences, having as its specificity the fact that its problems emerge and are focused on clinical practice, not being restricted to theoretical problems[1]. Culture, as a central construct, allows the development of clinical strategies that consider ethnic, migratory, minority and socioeconomic issues. An important basic assumption of cultural psychiatry is the understanding that the context is decisive for the formation of the clinical reality, each time singular and, therefore, its disregard leads to a series of obstacles in the service. The first part of this essay will take a short historical journey on Brazilian psychiatry and its teaching, highlighting its colonial traits. Then, the importance, within the training of residents, of the consistent teaching of cultural aspects of psychiatry will be highlighted.

BRIEF TRAJECTORY OF BRAZILIAN PSYCHIATRIC TEACHING

Brazilian psychiatry begins its formal teaching with the creation of the first medical schools, around 1832, the year that the academies in the states of Rio de Janeiro and Bahia became medical schools[2]. Prior to this period, medical education was prohibited as part of the colonial pact. The creation of the first medical schools coincided with a period when psychiatry was defining itself as a new specialty. Machado[3], in an analysis of theses by Brazilian physicians on the subject of mental alienation presented at the medical schools in Rio de Janeiro and Bahia, in the mid-nineteenth century, states that the theses were "Supported by foreign authors, notably French, the reference to the Brazilian situation does not exist or is occasional"[3] (p. 383). It thus can be observed that the first Brazilian writings on the subject of mental illness were strongly influenced by French physicians and did not include major concerns on the particularities of the Brazilian territory.

The first Brazilian psychiatric hospital dates back to 1852, the Pedro II Mental Asylum (*Hospício Pedro II*), in the city of Rio de Janeiro[4]. During the second half of the 19th century, in several provinces, similar to what happened in Rio de Janeiro, exclusive hospitals were created for the treatment of the medically insane[5]. Historiographic evidence reveals the constant request, by medical authorities, for the construction of these hospitals, aiming to provide a specific treatment facility for mental illness on Brazilian territory[3,5]. The doctors' idea was that mental illness required a specific institution for its treatment. Michel Foucault[5], in his 'History of Madness', talks about how the psychiatric hospital was the emergency surface for the delineation of psychiatry, as a medical specialty, and for the formation of the experience of the madness that accompanies it. The birth of psychiatry was associated to the birth of the psychiatric hospital as the treatment model. Hickling, eminent psychiatrist and researcher of colonialism in health, highlights how the proliferation of psychiatric hospitals in the New World was part of a colonization movement of mental health practices[6]. This means declaring that the model of care for mental disorders established in Europe was used in other parts of the world without due concern for territorial particularities.

In the first half of the 20th century, inspired by Morel's degeneration theory, Brazilian psychiatry developed a eugenics movement. Jurandir Costa Freire, in his work, "History of Psychiatry in Brazil: an ideological cut", discloses the eugenic ideals contained in the Brazilian League of Mental Hygiene[7]. The league, founded in 1923, initially operated "through propositions of progressive improvement of the race, which was the psychiatric equivalent of the ideology of the progressive racial whitening of the population"[7] (p. 52). Subsequently, "the Brazilian psychiatrists abandoned the idea of Aryanization or progressive racial whitening and retained the ideology of racial purity from racism"[7] (p. 52). The central concern of this movement was the prevention of mental disorders. The concepts of degeneration and the quest for racial purity were ways to strengthen the population and prevent the development of mental illness. The type of prevention that the Brazilian League of Mental Hygiene sought was of a frankly discriminatory nature. Marchin and Mota[8], in a historiographical research on the Juquery mental asylum and its creator Franco da Rocha, between the years 1898-1920, show several psychiatric conceptions and practices based on racial prejudices.

There is no robust evidence on the teaching of psychiatry in the 19th century and the first half of the 20th century. Picon and Castaldelli-Maia affirm that the teaching of psychiatry in Brazil, until the implementation of medical residencies, was not structured, being based on the experience of older physicians and centered on psychiatric hospitals[9]. The authors, however, do not clarify the historiographic evidence that supports such claims.

From the large psychiatric hospitals to the current practice, major changes have taken place: the Brazilian

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psychiatric reform, the development of psychopharmacology, the standardization of diagnoses into categories defined by criteria[10-12]. Nikolas Rose[13] highlights how the central aspect of psychiatry is currently organized through the "neuro" paradigm. The novelties created by technological development allowed direct interventions on the brain through the neurotransmission modulation with psychotropic drugs or through neurostimulation techniques; neuroimaging exams allow the functional and anatomical observation, enabling the visualization of correlations between specific areas and circuits with mental disorders; genetics and epigenetics show the great complexity between genes, the environment and a changing brain[13]. The author highlights how technological advances in the area of neuroscience have changed the structure of psychiatry and the management of mental disorders.

The formalization of the teaching of psychiatry in Brazil, through medical residency, is recent. Its beginnings, in the year of 1948, in a non-university hospital in Rio de Janeiro, was followed by the creation, in 1951, of the residency at the Hospital das Clínicas of the University of São Paulo (USP). The introduction of the medical residency model represented a great advance in teaching. Initially, the residency lasted two years and, as of 2007, after a series of criticisms about the short training period, it increased to three years[9]. This longer teaching time is crucial for the quality of the training. Coelho et al.[14] performs a critical analysis of residencies in psychiatry; the study had little data from Brazilian curricula and, despite the lack of available information, the authors assess a gap in relation to what is recommended by the World Psychiatric Association. Among the programmatic subjects that need improvement, psychotherapyteaching, integration with neurology, research and the latest diagnostic and therapeutic advances[14]are highlighted.

There are currently 34 residency programs in psychiatry registered by the Brazilian Association of Psychiatry. There are no direct studies on the curricular structure of psychiatry courses in Brazil. The difficulty in carrying out these studies is the limited availability of curricular information accessible on the institutions' websites[14]. However, it can be raised as a hypothesis to be investigated that the teaching disregards the local specificities of Brazil. As an indirect subsidy for this hypothesis, there is historiographic evidence that demonstrate, throughout the history of psychiatry in Brazil, the hegemonic influence of the productions of European and North American psychiatry[3,7]. Specific studies about the Brazilian psychiatry curriculum are necessary to deny or confirm such hypothesis.

DECOLONIAL ATTITUDE

It is essential that medical education adopt a critical attitude in its curriculum structure. The central thesis of this essay is that teaching in cultural psychiatry can offer residents useful clinical tools, training them to meet the specificities and challenges of Brazilian mental health. First, by recognizing the historical, ethnic and sociocultural particularities of our population and territory. Second, by helping to understand the historicity and context of the emergence of the productions of psychiatry itself. It is important to emphasize that consistent teaching on cultural issues is not opposed to neuroscience, psychopharmacology or biomedicine, but that it seeks to help the application of such disciplines in the clinical challenges where their action is necessary. Going a little further, it is possible to propose that adequate teaching in cultural psychiatry is also part of a decolonial attitude in teaching.

Before we go on, it is necessary to highlight some effects of colonization on psychiatry. Colonialism is a large-scale social phenomenon, like urbanization and industrialization, with profound negative impacts on countries at the periphery of the globe. Psychiatrist Franz Fanon describes that "The colonial world is a Manichean world"[15] (p. 30). On the one hand, we have the colonists with their legitimized practices and, on the other hand, the colonized with their silenced and devalued practices[15]. This means to affirm that the knowledge originating from Europe (settler) is considered valid and with reliable access to reality; at the same time, the knowledge of the colonized world is disqualified. It is an asymmetric dialectical logic; it takes the denial of local specificities to boost a universal truth of a knowledge that claims to be neutral and disinterested.

Philosopher Maldonado-Torres considers the decolonial attitude as a type of modification of the patterns of being, knowledge and power[16]. The decolonial attitude would consist of measures that go against the neglect and devaluation of knowledge productions and modes of existence of peripheral countries. It is important to emphasize that the decolonial attitude is not a denial, now in the opposite direction, of European knowledge and practices, but, in a very different way, it implies dignifying the productions and specificities of the non-European world as also essential for knowledge. Supported by the decolonial perspective proposed by Maldonado-Torres, it is up to the Brazilian psychiatric education to raise strategies that reactivate Brazilian particularities and are not satisfied with simply reproducing the models of care and teaching in mental health produced in developed countries.

The development itself of the field of cultural psychiatry can offer interesting perspectives on decoloniality. Antic[17],when analyzing the different productions of cultural psychiatry, identifies some waves of psychiatric thinking about diversity. Psychiatrists, before the Second World War, tended to approach diversity in terms of biological variability, in hierarchical terms, between the races, that is, certain races had superior

characteristics in relation to others; in the post-war period, driven by the atrocities that the racist conceptions of Nazism promoted worldwide, efforts were made to assert biological and psychological equality for all peoples, with differences being explained by cultural variations and no longer by biological or racial ones. In recent decades, prompted by research by several non-Western psychiatrists, there has been a critique of universalism, implicit in the idea of equality, and an emphasis on the importance that socioeconomic, historical and cultural encounter aspects have on the mental health of different human groups, in addition to an effort to highlight that psychiatric productions, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), constitute a possible form (and not the only one) of psychiatric production[17].In the field of teaching, the oldest training center in cultural psychiatry - McGill University - highlights how one of the main focuses of learning is the critical evaluation of the cultural aspects of psychiatry itself and of biomedicine[1]. The Canadian group considers that the identification of assumptions of psychiatric practice and theory are crucial for good practices.

The decolonial perspective of cultural psychiatry distances itself from the exoticism of the non-Western, which sought a radical alterity in biology or culture. Its challenge is to consider the challenges of intersectionality in mental health (gender, class, ethnicity, religiousness) and of the cultural encounter. Moreover, this decolonial attitude dethrones biomedicine from the position of a single practice and places it as a possible way of producing mental health with historicity and context[17,1]. The abyss, once insurmountable, between European and non-European knowledge ceases to exist. By forgetting the abyss, it is possible to escape the Manicheism that colonial thought imposes. The challenge is not to seek a superior form of knowledge, but to open bridges of dialogue between different types of knowledge.

Teaching in cultural psychiatry can, if aligned with the latest advances and research in its own area, be oriented towards a decolonial attitude. There is a decolonization of the field of knowledge, to the extent that European and North American psychiatric productions, contrary to our history of uncritical acceptance, are taken as fundamental knowledge, but originating from specific cultural repertoires. The task of the decolonial attitude is to bring about a positive encounter between Brazilian specificities and the international production of knowledge.

A limitation of this essay is the small number of studies on the curriculum and the teaching of the cultural aspects in psychiatry residency programs in Brazil. These studies would be important to strengthen the thesis of this essay. Teaching in cultural psychiatry is not a panacea for the training of residents. This area must be understood as capable of helping to enable the resident to develop tools and clinical skills to work in a complex, diverse and unequal country such as Brazil. One risk that studies in cultural psychiatry incur is that of reinforcing an unhealthy division between culture/biology or body/mind. The constructs around culture should not replace or confront advances in biomedicine in any way. The challenge of cultural psychiatry is to favor the productive meeting of different perspectives, always supported by the challenges that the clinic does not fail to bring.

CONCLUSION

Teaching in cultural psychiatry integrates national and international curriculum guidelines[18,19]. Cultural aspects are important tools in the training of residents. It is through practical and theoretical development on topics related to culture that the doors to coherent and decolonial medical education are opened. This, in practical terms, implies teaching that takes Brazilian specificities and local productions into account. Moreover, in a country marked by strong socioeconomic inequalities, teaching in cultural psychiatry increases the competences to work in this scenario and also trains the resident to deal with situations of language barrier or intercultural contact with different populations. Through the cultural assessment of the context, it is possible to develop practical skills to deal with small and large alterities within the clinic.

AUTHORS' CONTRIBUTION

Danilo Silveira Seabra: (Corresponding author), Study concept (Lead), Data curation (Lead), Formal analysis (Lead), Supervision (Equal), Visualization (Lead), Writing – original draft (Lead), Writing – review and editing. Lívia Ciaramello Vieira: Study concept (Equal), Formal analysis (Equal), Methodology (Equal), Project management (Equal), Supervision (Equal), Writing – original draft (Equal), Writing – review and editing (Equal). Luciana Andrade Carvalho: Conceptualization (Equal), Investigation (Equal), Project administration (Equal), Writing – original draft (Equal), Writing – review & editing (Equal). Lucas Naufal Macedo: Study concept (Equal), Research (Equal), Project Management (Equal), Writing – original draft (Equal), Writing – review and editing (Equal).

CONFLICTSOF INTEREST

The authors declare no conflicts of interest.

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