Exhibit P-72

IN REVIEW

Transcultural Psychiatry: Personal Experiences and Canadian Perspectives

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In the mid-1950s, a unique section of transcultural psychiatric studies was established within the McGill Department of Psychiatry. These personal recollections describe the backgrounds, methods, and motivations of those most involved and suggest why such a specialized study should have emerged in Canada and at McGill. Some of the major controversies and developments in the field are explored, focusing on the question of culture-bound syndromes and their occasional biological underpinnings. The relevance of transcultural psychiatry to psychiatric practice is discussed.

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My career in transcultural psychiatry began in September 1957 when I took up the post of "specialist alienist" (as advertised on the back cover of the *British Medical Journal*) at Aro Hospital in Abeokuta, Nigeria (then a British colony). This proved to be an enlightening experience. I was brought face to face with psychiatric phenomena for which my recently completed psychiatric training at the University of Western Ontario had not prepared me. The Yoruba people, among whom I found myself, had developed a sophisticated and internally consistent system of medicine and psychiatry that included etiological explanations and treatment methods which were often at variance with Western approaches (1).

For example, within the Yoruba system, besides the familiar drug treatment of the psychoses (traditional healers had long used rauwolfia root as a tranquilizing agent) (2), individuals with schizophrenia were sometimes directed to become initiates into spirit possession cults to prevent relapses. Patients and other cult members periodically entered dissociated states during which they temporarily assumed the personalities and speech of various members of the family of smallpox gods (Sopono). This behaviour was thought to please the spirits and thus prevent recurrence. Dissociation and something akin to multiple personality disorder, both regarded as pathological conditions in the West, could here form part of a treatment regimen (3). Transcultural psychiatrists and anthropologists have identified some therapeutic factors: emotional support from fellow cult members; increased self-esteem since the subject becomes a vehicle for the gods; a cathartic effect in that the possessing spirit may act out otherwise forbidden impulses (cross-sex, exhibitionistic, or sadistic behaviour for example).

Another surprise was the Yoruba use of cursing and blessing through the magical empowerment of words. Knowledgeable elders used medicine horns (usually cow horns stuffed with secret compounds of plants and other substances), which, if licked, could produce the result commanded. When the curse horn was used, often in the context of strife over a wife or between a powerful elder and a rebellious youth, the command might be "Go mad, die." Perhaps as part of a patient's discharge ceremony from an indigenous treatment centre, a blessing might be "You will never be sick again, no manner of witchcraft or sorcery will prevail against you, and you will get money and children." Within the Yoruba world, psychotic episodes can be triggered by cursing, but a magically empowered blessing may help prevent relapses (4).

I also found an illness among Yoruba and other West African students that I had not observed in Canada. Its symptoms were associated with study and featured the inability to read or to make sense of what was read. They could understand the letters but could not put them together as words. As commonly found in other psychiatric disorders among the Yoruba, instead of complaining of anxiety or of depression, these students experienced pain, burning, or crawling sensations in the head or body as accompaniment to their reading difficulties. Both secondary-school and university students were affected. I called this illness "the brain-fag syndrome

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because the students themselves often used that designation and attributed the illness to excessive use of their brains (5). This syndrome was very common, and almost all students appearing at psychiatric clinics suffered from brain-fag. Affected students not infrequently were forced to drop out of school because of their disability. The syndrome has been widely reported to occur in many other sub-Saharan cultures (6–8).

In the 1950s, the only department of psychiatry in the world with an established interest in such outlandish matters was at McGill University. Even before I left for Nigeria, I had corresponded with psychoanalyst Eric Wittkower (1899–1983) who, on the advice of Chairman D Ewen Cameron (1901–1967), had established McGill's section of transcultural psychiatric studies in 1955. Why did this new kind of training and research program make its debut in Canada and at McGill? HBM Murphy (1915–1987), an early member of the McGill group, liked to argue that it was because of the equal status afforded to French and English cultures in Canada's founding constitution. He suggested that the habit of accommodating 2 cultures rather than suppressing them fostered a mosaic ideology encouraging cultural groups to retain their identities. This official and mostly popular attitude of *vive la différence* contrasted with the idealogy of, for example, the US, which promoted a cultural "melting pot" by which immigrants were to be Americanized as quickly as possible. Further, Montrealers, especially the anglophones at McGill, were highly sensitized to the problems as well as the rewards inherent in the cultural mosaic.

Clearly, Cameron himself had a global vision for psychiatry. An early appearance of transcultural psychiatry on the world scene was an informal gathering at the Second International Psychiatric Congress in Zurich in 1957 (9). Cameron chaired the meeting that had been organized by Wittkower and which was attended by some 24 psychiatrists (from 20 countries), some of whom, such as Tsung Yi-Lin (Taiwan), TA Lambo (Nigeria), M Carstairs (Britain), CA Seguin (Peru), and Yap Pow-Meng (Hong Kong), were, or would soon become, major contributors to the field. A few years later, at the Third International Psychiatric Congress, held in Montreal in 1961, Cameron played a major role in the founding of the World Psychiatric Association (WPA). Cameron was its first president and edited the WPA Newsletter until his death in 1967.

I suspect that Wittkower too had a special interest in cultural influences or he would not have pursued Cameron's suggestion with such vigour. During his formative years, Wittkower had experienced 3 distinct cultures: German-Jewish, German and English. He was born in Berlin of Jewish parents. His merchant father, born in Edinburgh, admired the British enormously, and even though the family had returned to Germany by the time of Eric's birth, his father registered him as a British subject. During World War I, the Wittkowers suffered a good deal because of this British connection. Eric's father was imprisoned as a spy, his 3 British-born uncles were placed in an internment camp, and Eric was expelled from school. Later, during the Nazi regime, family members experienced tragedy because of their Jewishness. Eric's 2 older sisters and their husbands died in the Holocaust. Eric was discharged by the Nazis from his post as *Privat-Dozent* at the University of Berlin and left Germany in March 1933. Wittkower's cultural preoccupations may have been stimulated by these stark demonstrations of the significance and power of cultural identifications.

After 18 years in Britain, where he obtained his psychiatric training (including a Kleinian analysis) and developed an international reputation in the field of psychosomatic medicine, he joined the McGill Department of Psychiatry at Cameron's invitation in 1951 (10).

Five years later, Wittkower and Jack Fried (McGill Department of Sociology and Anthropology) produced their first mimeographed issue of *Newsletter / Transcultural Research in Mental Health Problems* (the first journal in the field, which after several transformations of title and content became, in 1997, *Transcultural Psychiatry*). The 1956 issue consisted of excerpts from the letters of 16 psychiatrists (working in 14 countries) who had responded to Wittkower and Fried's mailed questionnaire. Respondents had been asked: "On the basis of your experience can you describe psychiatric problems that occur in your country which contrast in their character, incidence (frequency) or intensity with those in other countries?" and "Do you feel that certain kinds of psychiatric problems are characteristic of limited segments of the population such as ethnic or racial groups, or certain geographical locations or social classes?"

By 1966, Wittkower had further elaborated his views of the scope of the field (11):

> a) exploration of similarities and differences in the manifestation of mental illness in different cultures; b) identification of cultural factors which predispose to mental illness and mental health; c) assessment of the effect of identified cultural factors on the frequency and nature of mental illness; d) study of the forms of treatment practiced or preferred in different cultural settings; and e) comparison of different attitudes towards the mentally ill in different cultures.

Views at that time implicitly held that Western-defined psychiatric disorders were paradigmatic—that they were in some way more "real" than any that might only occur outside the Western world. Certainly Western treatment modes, based on scientific facts, were deemed much superior to the etiological notions and preposterous therapies of some primitive cultures. Smallpox spirits do not really cause psychosis, nor can psychosis be cured by offering up animal sacrifices. Implicit also was the idea that the psychiatry of the future will result from the refinement of already-established Western knowledge of diagnostic patterns, etiological notions, and forms of treatment.

Fortunately, Wittkower's first *Newsletter* caught the attention of HBM Murphy, who in 1957 was completing his PhD in sociology at the New School for Social Research in New

York. His thesis was entitled "Ethnic Variations in Juvenile Delinquency." Murphy, a Scot, graduated from Edinburgh Medical School in 1938. During World War II, he was a paratrooper and medical officer with the British Army (Special Operations). After the war, he worked with international organizations concerned with post-war refugee rehabilitation in Europe, Israel, and Australia. Murphy attributed his interest in culture and psychiatry relations to this period of refugee work. In the various European refugee camps, hospitals, and prisons, cases were clearly distributed according to cultural origins:

> The prisons had a marked excess of Polish adolescents placed there, not for violence or theft, but for a stubborn determination to have firearms in their possession despite the strict laws against this, and despite the fact that they often did not know how to use them, having acquired them only after the end of the war. Some surgical wards were disproportionately full of Jewish patients, not people suffering from the after effects of physical or nutritional mistreatment in the concentration camps, but people who were seeking operations which they did not need and whom the surgeons could not understand.

Murphy at the time realized that these were "psychiatric" cases—here were epidemiological differences calling for as yet unknown cultural interpretations (12).

For several years in the early 1950s, Murphy directed the Student Mental Health Service of the University of Malaya in Singapore. Here he conducted one of the first transcultural epidemiology studies—collecting and analyzing data on suicides, juvenile delinquency, and psychosis, contrasting Singapore's Tamil (Indian), Chinese, and Malay populations. He used this data for his MD thesis for Edinburgh University and for his PhD thesis in sociology; summaries of these unique epidemiological investigations were published in Wittkower's *Newsletter* (numbers 3 and 6). According to Murphy's analysis, differences in pathology in the 3 groups could be accounted for best by cultural factors, rather than by "anomie" or social disorganization. With this background, Murphy joined Wittkower in 1959.

Like Murphy, Henri Ellenberger (1905–1993) was impressed by Wittkower's first newsletters. Then on the staff of the Menninger Clinic in the US, Ellenberger had also been for many years interested in cultural influences on psychiatry. Of Swiss-French Huguenot descent, Ellenberger was born to missionary parents in South Africa. He received his medical and psychiatric training in France and Switzerland and immigrated to the US in 1953. While in Switzerland, he published an early description of what would later be designated a "culture-bound syndrome" (CBS)—syndromes present in some cultures but not in others because of psychosocial influences. While working in the women's division of a psychiatric hospital in Switzerland, he observed among his patients housewives who were driven by an all-consuming need to keep a tidy house: "From morning to night, the housewife cleans with her broom and duster. Even Saturday morning, when everyone is free, she sends her husband out with the children, so that she can devote her efforts entirely to cleaning." Patients characteristically refused to use labour-saving devices and disdained less meticulous housekeepers. He designated this neurosis *Die Putzwut* (13). Ellenberger noted that although English and French cases occasionally occurred, the disorder was most prevalent and disabling among Swiss-German housewives. He also found the latter especially difficult to treat because the psychotherapist "hasn't only to deal with the resistance of the patient, but the family and above all the entire entrenched traditions and values of the culture."

Notably, Ellenberger's early observations on cultural influences were made within European cultures. Unlike most early transcultural psychiatrists, Ellenberger like Murphy, understood that all cultures powerfully influence psychiatric phenomena—as much among Germans and Americans as among Samoans and Yoruba. In 1965 Ellenberger wrote one of the most comprehensive early reviews of the field (which he liked to call ethno-psychiatry rather than transcultural psychiatry) in the *Encyclopédie Medico-Chirurgicale* (14). Ellenberger spent only 3 years with Wittkower, leaving for the University of Montreal's Department of Criminology in June 1962 (15).

Frank František Engelsmann was another early member of the McGill Section. Born in Czechoslovakia, he was 17 years old when the German invasion of his homeland in March 1939 raised the curtain on World War II. He obtained PhDs both in philosophy (1948) and psychology (1966) from Charles University in Prague. An expert in psychological testing, he wrote a major textbook in the field. His first contact with transcultural psychiatry was in 1959, when Eric Wittkower lectured about cultural influences on depression at the First Czechoslovak International Psychiatric Conference in the Czech spa Jesenik. Because of his proficiency in psychological testing and rating scales, he was invited to join the WHO International Pilot Study of Schizophrenia group in Geneva in 1967. With the help of Wittkower and Chairman Robert Cleghorn, Engelsmann joined McGill in late 1968 and remains a pillar of the Section—providing expertise in research design and analysis and being proficient in several languages. Over the years he has written scores of book reviews, abstracts, and commentaries for the Section's publications.

In emphasizing these Canadian and McGill contributions, I do not wish to imply that Wittkower and his group were the first to enter the transcultural field. Many important contributors preceded them, but whereas they explored uncharted domains, Wittkower and his McGill group were the first to erect a permanent settlement.

These earlier explorers included Emil Kraepelin (1856–1926), who was the first psychiatrist of stature to concern himself with the field. He called it "comparative psychiatry" (*Vergleichende Psychiatrie*) (16,17). In 1903–1904 he spent several months in Java at the Buitenzorg (now Bogor) mental hospital, which was ideal for comparative purposes because there were sizable groups of both Javanese and

Dutch patients (Java was part of the Dutch East Indies at the time). Kraepelin found that the European patients suffered the same illnesses as those at home. But Javanese patients differed in several ways: cerebral syphilis and general paresis (major Western psychiatric problems during that prepenicillin era) were absent. European types of severe depression with self-castigation were also absent among Javanese, as were disorders related to alcohol abuse (the Javanese are Islamic). Although approximately equal proportions of patients suffered from dementia praecox, the delusional systems of Javanese patients were less developed and hallucinations less common. Even so, Kraepelin believed that they suffered the same dementia praecox as did Europeans (16).

Other important early contributors included Shoma Morita (1874–1989), the Japanese inventor of Morita therapy (a kind of withdrawal, rest, self-examination, and social reintegration therapy), who was probably first to describe social phobias (*taijin kyofusho*), which are highly prevalent among Japanese (18), and Hong Kong psychiatrist Yap Pow-Meng (1921–1971), who trained in medicine and psychiatry in Britain, developed transcultural psychiatry at the University of Toronto, and probably coined the expression "culture-bound syndrome" (19). Better known to Canadian psychiatrists are Alexander and Dorothea Leighton, who published one of the clearest early accounts of a non-European healing system among the Navaho (20), and British psychiatrist JC Carothers (1904–1989), who wrote the influential "The African Mind in Health and Disease" for the WHO (21). Many anthropologists and psychologists, including George Devereux, Geza Roheim, Ralph Linton, Edward Sapir, Margaret Mead, Juris Draguns, and Anthony Marsella, also made significant early contributions.

Transcultural psychiatry from its inception has concerned itself with whether cultural influences can create psychiatric disorders such that they are found in some cultures but not in others. Although the question seems simple, this concept of CBS has given rise to considerable controversy.

Some point out that all psychiatric disorders are bound by culture, as much those included in Western nosologies as any found in Samoa or Korea. Ellenberger has detailed how our Western disorders and modes of treatment have transformed over time on the basis of cultural changes (22). He has delineated the diverse cultural forces that are at work in shaping psychiatric phenomena and our attitudes toward them. These attitudes extend beyond the influence of psychiatrists, psychologists, and patients to be formed by newspaper reports, novels, drama, insurance companies, television advertisements, and the Internet, to mention only a few influences (15). Patterns of psychiatric disorders and their epidemiology are much more susceptible to cultural influences than are organic diseases. Witness the recent emergence of such illnesses as burnout, chronic fatigue syndrome, fibromyalgia, and posttraumatic stress disorder; today we find that what we once called "shyness" is "social phobia"—and according to drug company advertisements, it is one of our most prevalent neuroses.

Even though our culture shapes us, surely biology is also a significant factor. Some major disorders like schizophrenia, manic-depressive psychosis, and some types of psychoneuroses most likely can be universally identified. It is still reasonable to ask whether some cultures create illnesses that do not occur in other cultures. Today it is argued that one of the best examples of a CBS is anorexia nervosa—a disorder that seems to be restricted to affluent Western cultures and cultures under strong Western influences. This view was first proposed by Yap Pow-Meng, who in 1969 suggested that the Western world might harbour CBS just as do exotic cultures; he mentioned as possible examples, "homosexual panic and perhaps school-phobia and anorexia nervosa" (23). However, further observations are required to support the view that anorexia nervosa is a CBS. It is relatively easy to determine whether a syndrome occurs in a given cultural area, but very difficult to show that it is absent from all others. Even in the West, anorexia nervosa is relatively rare, and in isolated areas where psychiatrists are few, cases of self-starvation may yet appear.

The differing views of anthropologists and psychiatrists have given rise to most of the controversies over CBS. Within medicine, it is pretty clear what is meant by "syndrome." The medical dictionary definition is "a cluster of signs and symptoms which together constitute the picture of a disease." Some anthropologists use the expression differently. Cassidy has proposed a "meaning-centred" definition of CBS (24). She suggested that when considering the CBS status of a given disease, notions of etiology and treatment should be included as well as signs and symptoms. Cassidy exemplified her views using protein-energy malnutrition (*kwashiorkor*). Although she admits that the symptoms of kwashiorkor are the same around the world, patients and their families often harbour notions of cause that differ radically from those held by the Western-trained physicians who treat them, with the result that prevention and treatment programs usually fail. On this basis Cassidy believes that kwashiorkor should be seen as a CBS. On the other hand, the suggestion that the designation of a syndrome should include notions about its cause would make very little sense to most physicians (including transcultural psychiatrists). As research progresses, views of cause often radically change. That a diagnosis should change with varying views of etiology would seem highly inappropriate within the medical world (19). Yet in some ways, these anthropological views have a certain cogency. Clearly, causal notions may sometimes shape an illness and determine symptomatology. Charcot notoriously shaped hysteria at Salpetriere Hospital in Paris.

The complex nature of this CBS controversy can further be illustrated by considering *amok*, one of the earliest disorders to be regarded as culture-bound. Nineteenth-century reports

described amok as peculiar to Malays. Amok is characterized by a sudden outburst of indiscriminate homicidal frenzy directed toward bystanders and terminated by the killing, suicide, or capture of the assailant. Subjects are not usually psychotic and, according to some observers, experience an altered state of consciousness with subsequent amnesia for the episode. Anthropologist JE Carr linked amok to specific cultural features of the Malay population and proposed that: "Amok, as it is conceptualized by the Malay, will be found prevalent only among people who share Malay conceptualizations and behavioural norms. Behaviour similar to the amok phenomenon will be found in other cultures but it will be called a different name and conceptualized and valuated in other ways" (25). However, psychiatrist B Burton-Bradley described several cases from Papua New Guinea (26). He felt that, in his cases, amnesia for the killings was not always present and that sometimes the victims were known. Still, he felt they should be included in the concept of amok. Similarly, J Westermeyer has drawn attention to multiple murders in Laos—using hand grenades rather than knives—that share common characteristics with amok (27). Increasingly frequent mass indiscriminate killings by apparently nonpsychotic individuals in the US, Canada, Britain, and elsewhere also seem very like amok. Indeed, it might be more pertinent to conceptualize these killings as a matter of social disintegration than as culturally constructed phenomena (28).

Latah is another famous and controversial CBS. Remarkably, the latah dispute has generated more pages of print in psychiatric and anthropological writings than any other CBS. This is odd because the persons afflicted are often not locally regarded as ill, seldom seek treatment, and, for the most part, provide entertainment for their fellows. Latah has been characterized as a "syndrome usually triggered by a fright (a loud noise, unexpected gesture, even a stimulus word such as 'snake' or 'tiger') which results in some or all of the following behaviour: an exaggerated startle reaction, echolalia, echopraxia, coprolalia, copropraxia and automatic obedience" (29). At first it was thought to occur only in Malay populations. But New York neurologist George Beard (1839–1883), who invented the concept of neurasthenia in 1864, was also among the first to describe in detail a condition apparently identical to latah in non-Malay cultures. He found it in Northern Maine. Having heard mention of an unusual neurological disorder around Moosehead Lake, he visited the area in 1880. Cases were not hard to find; 2 afflicted individuals worked at his hotel. Never having heard of latah, he referred to these cases as the "jumping Frenchmen of Maine" (30). Based on observations of 50 cases, including 14 in 4 families, the syndrome struck mostly lumberjacks of French-Canadian descent. One of his subjects, for example, was sitting, cutting his tobacco with a knife and Beard startled him by striking his shoulder and shouting "throw it." Beard described his reaction: "Almost as quick as the explosion of a pistol, he threw the knife, and it struck the beam opposite; at the same time he repeated the order, 'throw it' with a certain cry as of terror or alarm" (31). This behaviour and that of other subjects described in his papers indicate the jumpers to be highly similar or identical to latah cases.

During the next few years, Beard's publications on jumpers echoed around the world. Gilles de la Tourette, a student of Charcot, was at the time collecting cases of what would become known as Tourette syndrome (TS). He erroneously considered Beard's jumpers to be the same as the patients he was investigating. (Although, like the jumpers, TS patients often suffered coprolalia and sometimes echolalia, their symptoms were not triggered by startle. The major feature of TS patients—repeated, involuntary motor tics—was not part of the "jumping" picture.) Beard's paper was followed by other descriptions of cases that appeared to be similar to the jumpers: *myriachit* in Siberia (32) and the previously described latah of Malaysia and Indonesia. Tourette's 1884 article on "jumping, latah and myriachit" (33), which claimed that these 3 conditions were the same as his cases of "convulsive tics," led to sometimes acrimonious debate about whether they really were the same and who it was who first described these conditions (34). Today, most transcultural psychiatrists would see TS as a distinct entity but jumping, myriachit, and latah as the same illness with different labels.

Again anthropologists argued that latah is a unique disorder emerging from the distinct Malay culture; and that although latah-like behaviour may occur in other cultures, it is not the same illness. Ronald Simons has cogently argued that latah phenomena are culturally shaped, exaggerated startle responses not restricted to Malay or Indonesian cultures (35). R Rabinovitch (36), a Montreal neurologist raised in La Macaza, Quebec, had previously described how the horseplay of French-Canadian lumberjacks that he had witnessed as a youth could have generated the odd startle reactions of the Beard's jumpers. Anthropologist Kenny (37) and sociologist Bartholomew (38) would have none of this. Kenny claims that latah is intimately related to the fundamental values of Malay culture (37): "I explored in detail the contextual significance of latah in Malaya and Indonesia, and found that it is related to local witchcraft beliefs, to midwifery, to shamanism, to folk art and to fundamental ideas pertaining to the gaining of religious insight and power through loss of self." On these grounds he denies that other seemingly similar reactions such as jumping and myriachit could be the same as latah. Bartholomew, who married into a Malaysian extended family containing numerous latah cases, denies that latah is an illness at all and seems to argue that it is best regarded as a consciously manipulated attention-seeking measure (38). He also sees in the interpretation of latah as an illness an example of the medicalization of deviance.

Although in the early transcultural literature variations in psychiatric phenomena according to culture were assumed to be psychosocial in origin, some important cultural variations now appear to be at least partially biological. If Simons is right about the cultural shaping of the startle reaction as the

basis for the latah phenomenon, we have here an example of a CBS with both cultural and biological origins. And there are others. Striking cultural variations in alcohol abuse have long been evident: Chinese and Jewish populations are distinctly less liable to problematic alcohol use than are the Irish and at least some groups of Amerindians (39). Up until the 1970s, these differences were confidently attributed to such psychosocial features as child-rearing practices, lifestyles, and cultural or religious attitudes toward drinking. But more recent studies have identified a biological mechanism, the "flushing response," which offers a partial explanation. The flushing response reflects a Western versus Asian (Chinese, Korean, Japanese, Amerindian) difference in ethanol metabolism and is somewhat similar to the reaction of an alcoholic on antabuse (disulfiram) after ingesting ethanol. The flushing response includes, in varying degrees, flushing of the face, neck, and upper chest, tachycardia, hypotension, dizziness, pounding in the head, muscle weakness, sleepiness, and nausea. Various studies have found from 50% to 85% of Asians to show the flushing response as opposed to only 5% to 15% of Caucasians. Newborns show the same racial variations as adults.

The biological basis for the flushing response is not entirely clear, but like those reacting to disulfiram, flushers develop a high blood-acetaldehyde level after ingesting ethanol. Alcohol is converted to acetaldehyde by liver alcohol dehydrogenase (ADH), and acetaldehyde is further metabolized by aldehyde dehydrogenase (ALDH). An accumulation of blood acetaldehyde then may result from either an increased ADH activity or a decreased ALDH activity. It should be noted that the flushing response provides only a modest defence against excessive alcohol intake. Among the Japanese, for example, alcohol abuse has increased considerably in recent years, despite their susceptibility to the flushing response. Further, Amerindian groups suffer high levels of alcoholism.

Similarly, a good deal of discussion has recently concerned cultural variations in optimum dosage levels of tranquilizing and antidepressant drugs according to culture or race (40), differences that were originally discussed by HBM Murphy (41). At first these cultural variations were attributed to psychosocial differences, but now biological explanations predominate.

For most Canadian psychiatrists, transcultural psychiatry and its theoretical controversies may be of academic interest only. Still, transcultural psychiatry should have practical relevance to those who find themselves involved with immigrant and refugee patients and their families. Probably the most important lesson to be learned from transcultural psychiatry is the awareness that culture can often make an important difference—the difference between compliance or non-compliance with a treatment regimen, for example, or even of continuance in therapy. Of course, our immigrant patients do not expect us to know everything about all cultures. Some evidence of the physician's cultural sensitivity is often sufficient. Simple questions such as, "How do things differ in your country?" can be reassuring. Most will happily indicate where cultural factors are problematic—perhaps in views about how adolescents should behave or in expectations about male and female roles. For immigrants and refugees, the main difficulties are usually those of adaptating to Canadian culture and ubiquitous ethnic and racial prejudices.

Transcultural psychiatry is also important for psychiatrists who work with Amerindian or Inuit groups. Here, the work of Clare Brant (1941–1995) is of central importance. He was the first, and to my knowledge, the only Native psychiatrist in Canada. A member of the Mohawk Nation, he graduated in medicine from Queen's University in 1965 and, after practising as a family doctor for several years, completed his psychiatric training at the University of Western Ontario. Until his untimely death, he was an indefatigable advocate of aboriginal mental health and welfare. Among his many achievements, he founded the Native Mental Health Association of Canada and organized the Association's annual meetings. Brant also acted as advisor to the Ontario and federal governments on Native health policy.

For me, his most valuable contributions were his lectures and writings, which provided an insider's understanding of the special characteristics of Amerindian cultures. One paper stands out: "Native Ethics and Rules of Behaviour" (42). Brant for the first time explained the well-known conflict-suppression strategies of Amerindian groups and their survival function in the harsh Canadian north. He proposed 4 conflict-suppression traits: noninterference, noncompetitiveness, emotional restraint, and sharing. These elucidations were particularly helpful in my own work with the James Bay Cree (43).

Traditionally, Cree summers ended with the appearance overhead of vast formations of Canada geese as they followed established flyways down the James Bay coast. Summer settlements were abandoned; small groups of related families fanned out over their hunting territories to throw themselves upon the mercy of the subarctic winter. The senior male of each group was the owner of the families' shamanic drum, which permitted his special kinship with the local animals: through his kinship and drumming he was able to determine where game would be most plentiful in his territory. This strategy was not always successful, and sometimes families failed to emerge from the bush in spring. As Brant had pointed out, under such circumstances, group harmony was essential (42). Especially during the perilous winter, disobedience, jealousy, rivalry, or squabbling of any kind could be fatal for the entire group. The shaman was perhaps most important not for his supernatural powers, but for the fact that no one in the group questioned his authority. His word was final. And harmony meant the difference between life and death.

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Clinical Implications

- Cultural sensitivities of the psychiatrist may affect patient compliance and continuance in treatment.
- All cultures play a role in shaping psychiatric phenomena, as much German, French, and English as Yoruba and Cree.

Limitations

- As a historical review of Canadian contributions to transcultural psychiatry, many important figures have been neglected.
- No comprehensive survey of the field has been provided. Many important areas in the culture and mental health field, such as cultural definition of sex roles, issues of religion and psychiatry, and the effects of cultural disintegration, have received no attention.

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Résumé— La psychiatrie transculturelle : expériences vécues et perspectives canadiennes

Au milieu des années 1950, le département de psychiatrie de l'Université McGill a instauré une première section d'études psychiatriques transculturelles. Ces souvenirs personnels décrivent les antécédents, méthodes et motivations des participants actifs, et suggèrent la raison d'être d'études aussi spécialisées au Canada et à McGill. Certains des plus importants développements et des plus grandes controverses du domaine sont examinés, et l'accent porte sur la question des syndromes attribuables à la culture et de leurs répercussions biologiques occasionnelles. On aborde aussi la question de la pertinence de la psychiatrie transculturelle dans la pratique psychiatrique.