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Forthcoming international
events
Professor Hamid Ghodse CBE
Mohammed Abou-Saleh¹ and Nasser Loza²

Professor Hamid Ghodse passed away at his home on 27 December 2012 from lung cancer. Hamid was Professor of Psychiatry and of International Drug Policy, and Director of the International Centre for Drug Policy, St George’s, University of London.

His untimely death is a great loss to international psychiatry. After a career spanning over 40 years, Hamid’s contributions to world psychiatry are legendary and will be difficult to match. He was instrumental in bringing the Royal College of Psychiatrists to its current international standing. As Director of the Board of International Affairs in 2001, Hamid strengthened the structure, function, reach and impact of the international divisions and ensured their contributions to the annual meetings of the College. He established International Psychiatry and as Editor ensured its global reach and influence by recruiting contributions from countries that had little exposure in international journals.

The College conferred its highest honours on Hamid: in 2006 he was elected an Honorary Fellow and in 2011 he was given the Lifetime Achievement Award. He was elected International Fellow of the American Psychiatric Association (APA) and Honorary Fellow of the World Psychiatric Association (WPA). He was awarded the civil honour of CBE (Honorary Commander of the Most Excellent Order of the British Empire) in 1999 for his dedication to research and clinical practice.

He was immediate past-President of the International Narcotics Control Board (INCB) and former INCB President on 10 occasions between 1993 and 2011, a unique achievement with global impact. The INCB obituary expressed the deepest sorrow and highlighted Hamid’s achievements as a member of the INCB: ‘Professor Ghodse made major contributions to heighten the relevance of international cooperation among the community of nations in matters of international drug control, to which he brought his unique and outstanding academic and scientific knowledge, combined with remarkable leadership, wisdom and elegant diplomacy.’

Hamid held the first Chair in Addictive Behaviour in the UK in 1987, established by parliamentary action, at St George’s Hospital Medical School, University of London. He was an excellent clinical teacher and innovator in developing undergraduate and postgraduate training programmes in all healthcare disciplines. His legacy is in the large number of graduates who are indebted to him for providing them with excellent tuition in addictions. His most recent contribution was the development and implementation of a national undergraduate medical curriculum in addictions. It was endorsed by the Chief Medical Officer and the General Medical Council and is cited specifically in the latest edition of Tomorrow’s Doctors.

An educator at heart, Hamid was Chair of the subject panel of Psychiatry and Coordinator of Higher Degree Examinations at the University of London. Of his many positions he particularly cherished his role as Chair of the Association of Professors of Psychiatry in the British Isles and the Professors of Psychiatry Club.

Hamid’s applied and clinical addiction research was focused on patient benefit. Major interests were surveys of accident and emergency departments, long-term studies of coroners’ courts, and analysis of the Home Office Index of Addict Deaths. This research on mortality led to the development of a unique national database and the establishment of the National Programme on Substance Abuse Deaths (npSAD).

He published hundreds of papers and many books. Ghodse’s Drugs and Addictive Behaviour:
Physical and mental illnesses: implications of similarities and differences for services and law

Sean Roche PhD MRCPsych

It appears self-evident that psychiatry should be classified as a particular specialty within the broader field of medicine. Psychiatrists, being first and foremost doctors, have undertaken an identical basic training to their physician and surgical peers and, as in general medicine and surgery, the biomedical model is a central pillar of psychiatric practice. Within psychiatry, signs and symptoms are elicited, diagnoses made and very often physical interventions (in the form of psychotropic agents) are employed. However, familiar institutional conventions can conceal the fact that psychiatry suffers from greater uncertainty regarding its conceptual foundations than other fields of medicine. In fact, the conceptual challenges arising within psychiatry are reflected in its thriving field of philosophy, and although there exists a dedicated philosophy of medicine, no other specialty is equal to psychiatry’s breadth of conceptual debate.

Fulford (1998) has discussed psychiatry’s tendency to encompass a greater divergence in values than other specialties. Central to psychiatric theory and practice is the ‘biopsychosocial’ model. Ghaemi (2009, p. 4) expresses concern about the usefulness of this model, arguing that it ‘devolves into mere eclecticism, passing for sophistication’. But this pronouncement on the model’s failure may not indicate a fault with the model per se, but instead may merely highlight our limited understanding of the relations between its three domains. For psychiatry, elucidating the nature of the relations within the ‘biopsychosocial’ model is a particularly pressing task.

Here we will consider two conceptual problems that pose deep questions regarding the nature, or ontology, of the phenomena with which psychiatry deals. These conceptual challenges are central to achieving greater intelligibility of the biopsychosocial model.

**Medicine of the mind or brain?**

Traditional psychiatry, like medicine generally, has a primary theoretical and practical focus on a particular system or part of the body, in this case the brain. However, in addition to attending to the body, psychiatry is equally concerned with the ‘mind’. This means that a central issue for psychiatry is understanding the nature of the (psycho–bio) relationship between mind and body. This so-called ‘mind–body problem’ unfolds from the simple observation that conscious experience involves experiential properties, such as feeling warm or nauseous, smelling roses or hearing middle C. However, when scientifically investigating the body, or specifically the brain, we describe instead the physical properties of neuronal activation states, neurotransmitters, receptor binding and so on. The seemingly irreconcilable differences between the manifest properties of mind versus the properties of physical objects famously led the philosopher Descartes to the dualist conclusion that there are two distinct ‘substances’ – the mind and the body – that interact via the pineal gland.

Chalmers (2003) provides an overview of proposed philosophical solutions to this problem, including: several versions of mind–brain identity...
and the more biomedical approaches found in the clinical services into specific psychology services. The divergent use of 'mental' versus 'physical' concepts reflects this conceptual duality of mind and brain. Psychologists employ a language of beliefs, desires and intentions, whereas biological psychiatrists generally refer instead to the purported monoamine dysfunction in depression, for example. The divergent use of 'mental' versus 'physical' concepts is also demonstrated by the differentiation of clinical services into specific psychology services and the more biomedical approaches found in the psychiatric ward or clinic.

The distinction between the concepts of physical and mental is brought into sharp relief when forensic psychiatrists are asked to make judgements about criminal responsibility. At stake is whether we consider 'responsibility' to be grounded in the domain of beliefs, desires and intentions – what McDowell (1996) calls the 'space of reasons' – or the realm of physical laws. The law may exculpate offenders from full criminal responsibility if they suffer the dopamine dysregulation of schizophrenia, but how far should neurophysiological mitigation go? Gazzaniga & Steven (2005) note that, in the USA, 'Defence lawyers are looking for that one pixel in their client's brain scan that shows an abnormality – some sort of malfunction that would allow them to argue: 'Harry didn't do it. His brain did it. Harry is not responsible for his actions'.

Even if 'faulty neurons' are deemed culpable in court, it is far from clear that we could in principle make sense of a 'brain' being responsible for anything. Bennett et al (2007) argue that we can rationally attribute psychological predicates such as 'responsible' only to persons (not brains) embedded in linguistic communities. This tension between what we might call the purely physical or 'syntactic' aspects of causation in mental states and behaviour and the meaning-laden 'semantic' aspects is particularly acute in psychiatry, and especially at the interface with law.

The culture of psychiatry pragmatically reflects this conceptual duality of mind and brain. Where is mental disorder?

This is at first sight a strange question, but it signals another deep conceptual problem at the heart of psychiatry. Unlike in much of medicine, in psychiatry we must be open to the possibility that not only the causes but conceivably also components of the disorders we treat extend beyond the body. For many 'biological reductionists', it is axiomatic that mental disorders are brain disorders. However, there is a school of thought, most recently developed by 'extended mind' theories (see Clark, 2011), that conceptualises the mind as extending beyond the body and into the environment. From birth, individuals are 'enculturated' by language and other symbols, and brain changes occur throughout life via informational continuity with a changing culture. Therapists may discover individual beliefs or desires that cause suffering but that originate primarily in the culture. For example, a person with depression may hold a culturally derived belief that unemployment is shameful and yet be unable to secure a job. Schizophrenia, a disorder often regarded as quintessentially neuropathological, is associated with social isolation, adversity (particularly childhood abuse) and 'social defeat' (Boydell & Allardyce, 2011). The social dimension of psychosis is emphasised by the finding that schizophrenia can show significant placebo response, a response 'revel[ing] aspects of the biology of interpersonal relationships and the social environment' (McQueen & St John Smith, 2012, p. 2). If mental disorders are in part constituted by aspects of the social milieu, then we need to question a conception of neuronal pathology as the key locus of mental disorder, and perhaps regard such lesions as 'neural signatures' of broader sociocultural disorders. The crucial issue is how we conceptualise the relation of the social to the biological and psychological in the biopsychosocial model.

Conceiving mental disorders as 'extended' into society prompts a rethinking of how services are designed. Often patients are extruded from their milieu to the ward or the consulting room, and we risk focusing too narrowly on their particular experiences and the putative brain disorder that explains their suffering. However, according to the 'extended' model of mind, this is like the error of a physician who attends only to finger-clubbing without understanding it as a local manifestation of chest disease. It would be unfair, though, to caricature psychiatric practice. Child psychiatry embraces this systemic view when it employs family therapy. Adult psychiatry may use group therapies, and it operates within policies that address, for example, elder abuse and domestic violence; adult psychiatry also recognises the therapeutic importance of social networks and rewarding occupation.

'Meaningful' relationships in a family or social matrix are generally more important in the cause or constitution of psychiatric disorder than in general medicine or surgery. But the difference is relative, not absolute. Research suggests that 'semantic' factors such as one's perceived social status can seriously affect physical health (Wilkinson & Pickett, 2010). Consequently, psychiatry must place more emphasis on psychosocial approaches. In addition to the psychotropic modification of 'neural signatures', psychiatry must address the relations of patients to their immediate social context.
We were delighted to receive from Hong Kong Hanneke van den Akker and colleagues present a review of attitudes to people from sexual minorities in Africa, prepared by Marc Epprecht. We hear much about the serious risk of harm to people in some African countries who admit their sexual orientation is unconventional. Not all countries on that diverse continent are as intolerant as Uganda, and some – such as Botswana, Mozambique and Malawi – are acting to protect such minorities from discrimination. On the other hand, it is chilling to learn that neo-conservative Christian groups in the USA are providing money to Africans who want to force sexual conversion on deviants, reviewed in a report (available to download) entitled Colonizing African Values, by Dr Kapya Kaoma, an Anglican priest.

Amid the current controversy in the UK about whether or not homosexual couples should be allowed to marry in church, it is all too easy to lose sight of the fact that in most countries the mere admission that one’s erotic fantasies are directed towards the same sex could bring about social opprobrium, discrimination or even death.

Hanneke van den Akker and colleagues present an important analysis of health and happiness among homosexual couples in European countries. Their report is based on data gathered from households by the European Social Survey of over 30 countries; remarkably, only 9 countries could provide responses from more than 50 couples living in a same-sex relationship. The implication is that in many European countries it would not be acceptable to admit, even in a survey of this type, that one’s living arrangements reflect homosexuality. Their findings are provocative and indicate the need for a deeper understanding of the social adjustments such couples have to make, even in relatively enlightened countries such as the UK, Denmark and the Netherlands.

We were delighted to receive from Hong Kong a report about attitudes towards homosexuality among Chinese people, provided by Joseph Wu and Diana Kwok. The attitudes in question, surveyed among medical students and social work students, were surprisingly negative – especially among those with professed Christian beliefs. Sadly, it appears stereotyping and homophobia are endemic in school counselling services too. Unsurprisingly, the net effect of this prejudice on the mental health of people with a homosexual preference leads to a reduced quality of life.

Finally, we present a review of attitudes to people from sexual minorities in Africa, prepared by Marc Epprecht. We hear much about the serious risk of harm to people in some African countries who admit their sexual orientation is unconventional. Not all countries on that diverse continent are as intolerant as Uganda, and some – such as Botswana, Mozambique and Malawi – are acting to protect such minorities from discrimination. On the other hand, it is chilling to learn that neo-conservative Christian groups in the USA are providing money to Africans who want to force sexual conversion on deviants, reviewed in a report (available to download) entitled Colonizing African Values, by Dr Kapya Kaoma, an Anglican priest.

Among the relatively enlightened countries such as the UK, Denmark and the Netherlands, there are examples in medicine of the health-promoting use of law, such as the restriction of tobacco advertising and in Scotland the minimum pricing of alcohol. The Marmot review found social inequality to be detrimental to physical and mental health (Marmot et al, 2010). Perhaps greater public funds should be dedicated to policies or laws that modify the ‘meaningful’ aspects of the social matrix in the promotion of mental well-being.

This raises the issue of the purpose of mental health law, which tends to relate to ‘risk’. Attention is therefore narrowed to individuals, but this forecloses consideration of those social factors that have brought a person before the law or a mental health review tribunal.


Our report is based on data gathered from households by the European Social Survey of over 30 countries; remarkably, only 9 countries could provide responses from more than 50 couples living in a same-sex relationship. The implication is that in many European countries it would not be acceptable to admit, even in a survey of this type, that one’s living arrangements reflect homosexuality. Their findings are provocative and indicate the need for a deeper understanding of the social adjustments such couples have to make, even in relatively enlightened countries such as the UK, Denmark and the Netherlands. puzzle (family therapy, occupational therapy, social support). More broadly, psychiatric public health should address the social matrix at a population level; such a therapeutic framework is provided by the ‘ecological public health’ articulated by Lang & Rayner (2012), which integrates material, biological, social and cultural aspects in understanding the determinants of disease.

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HEALTH AND HOMOSEXUALITY

Health and happiness among homosexual couples in Europe

Hanneke van den Akker,1 Joris Blaauw,2 Marcel Lubbers,3 Rozemarijn van der Ploeg,4 Peer Scheepers5 and Ellen Verbakel6

Data from five waves (2002–10) of the European Social Survey were examined to see the extent to which heterosexual and homosexual couples differ in their health and happiness. Homosexual people had lower levels of self-rated health and happiness. We suggest that those who experience discrimination are more strongly integrated in their gay community, which, in turn, may bring positive effects in terms of happiness due to a sense of belonging, but may be accompanied by the specific health risks associated with this community.

It is often assumed that gays and lesbians suffer disproportionately from health problems (Frable et al, 1997; Sandfort et al, 2001). However, few studies have actually directly compared the health and happiness of heterosexual and homosexual people. These few studies have found that (sexually active) homosexual (and bisexual) people had lower levels of psychological well-being (e.g. Carlson & Steuer, 1985; Sandfort et al, 2001). We set out to answer the question: to what extent do heterosexual and homosexual couples differ in their health and happiness in the general population of European countries?

Previous insights

Although health and happiness are different aspects of people’s well-being, studies have shown that the two are strongly associated (Borgonovi, 2008). Previous research has also shown that the determinants of (self-rated) health and happiness are comparable and partially consistent. Not surprisingly, health declines as people age. Unmarried people, poorly educated people, unemployed as well as non-religious people more often report poor health (Huijts & Kraaykamp, 2012). Moreover, all respondents were asked to indicate the sex of all household members and to specify their relationship. Respondents were asked to indicate the sex of all household members and to specify their relationship. Moreover, all respondents were asked whether they felt discriminated against because of their sexuality. We thus can identify same-sex couples who feel discriminated against and same-sex couples who do not.

We selected respondents aged between 15 and 80 years (n = 82 797). We included only those 9 countries in which we found at least 50 homosexuals living as a same-sex couple. We anticipated and found empirical evidence that the incidence of same-sex couples is lower in countries with a more unfavourable public opinion towards gays and lesbians (r = −0.60, disapproval rates from van den Akker et al, 2013). Consequently, this study includes countries with a relatively favourable public opinion towards homosexuality (Belgium, Denmark, France, Germany, Ireland, the Netherlands, Sweden, Switzerland and the UK).

Self-rated health, considered to be a valid measure of people’s mental and physical condition (Huijts & Kraaykamp, 2012), was recorded on a five-point scale, ranging from ‘very bad’ (0) to ‘very good’ (4). Happiness was measured by asking how happy respondents were, with responses ranging from ‘extremely unhappy’ (0) to ‘extremely happy’ (10).
Analyses and results

We conducted multilevel analyses of the variance in levels of self-rated health and happiness between countries and between individuals within these countries. We assessed the extent to which individuals in same-sex couples – those who feel discriminated against as well as those who do not – differ from different-sex couples in terms of the statistical mean scores on self-rated health and happiness. We initially found no evidence for lower levels of health among people in same-sex couples, whereas their levels of happiness were lower than those of their counterparts in different-sex couples.

Sandfort et al. (2001) found that gays and lesbians are better educated, and better-educated people tend to report better health. We checked whether important determinants of health and happiness were differently distributed over homosexual and heterosexual individuals and whether, therefore, health differences varied similarly. After statistically controlling for these determinants, we found, in line with our expectation, that people in same-sex couples did report worse health than their counterparts in different-sex couples, but this held more strongly for those who felt discriminated against. We also found that people in same-sex couples reported lower levels of happiness than people in different-sex couples, but this held more strongly for same-sex couples who did not feel discriminated against.

In sum, our results suggest that homosexual people in couples are less healthy and less happy than heterosexual people. In addition, homosexual individuals who felt themselves to be discriminated against reported worse health and more happiness than homosexual individuals who did not experience discrimination. Furthermore, we found that the happiness gap between non-partnered and partnered heterosexuals was larger than the gap between homosexual and heterosexual partnered individuals, implying that marital status is a stronger determinant of happiness than is sexuality; this was not the case for self-rated health.

Consistent with previous research, we found that people who were well educated, those in paid employment and those who frequently attended church rated their health and happiness higher than their counterparts. Finally, we found that both health and happiness declined with age.

Table 1 shows a summary of the results for each country separately to assess whether our general findings were reflected in country-specific patterns. Because the group sizes differed substantially between the countries, findings of statistically significant differences in the parameters would be expected to vary. The pattern is nonetheless largely consistent. In most countries, homosexual people reported worse health and lower levels of happiness than their heterosexual counterparts. Second, although the pattern is a bit more mixed, in the majority of countries homosexual individuals who felt discriminated against reported lower levels of health but higher levels of happiness than homosexual people who did not feel discriminated against.

Discussion

This study corroborated the finding that homosexual people have lower levels of self-rated health and happiness. Discrimination seems to be a partial explanation at most, considering our finding that those who felt themselves to be discriminated against reported worse health but higher levels of happiness than homosexual individuals who did not feel themselves to be discriminated against. We therefore postulate an alternative mechanism: the former tend to be more strongly integrated into a gay community; this may bring positive effects in terms of happiness, due to a sense of belonging (Huijts & Kraaykamp, 2012), but may bring negative health effects because of the specific health risks associated with this particular community.

We observed only a selective set of countries: those with a gay-friendly climate. It is not unlikely that the size of the gap in health and happiness by sexual orientation would be larger if more gay-unfriendly contexts were included in the sample. Furthermore, our data related only to people living as couples, and marital status is an important determinant of well-being. For a complete insight into differences in health and happiness by sexual orientation, replication of this study among single homosexual and heterosexual people is needed.

References


HEALTH AND HOMOSEXUALITY

Attitudes towards sexual minorities among Chinese people: implications for mental health
Joseph Wu1 and Diana K. Kwok2

Heterosexuality continues to be regarded and adopted as a norm in the majority of Asian societies. In Hong Kong, lesbians and gay men are still encountering unfavourable attitudes from the general public (such as stereotyping and discrimination). This paper briefly reviews the legal and cultural context and notes in particular the situation in schools.

Despite the fact that homosexuality has been removed from the Diagnostic and Statistical Manual of Mental Disorders as a kind of mental illness since 1973 by the American Psychiatric Association, heterosexuality continues to be regarded (and adopted) as the norm in the cultures of a majority of Asian societies (Lim & Johnson, 2001). For instance, in Hong Kong, lesbians and gay men are still encountering unfavourable attitudes from the general public (such as stereotyping and discrimination) (Hong Kong Christian Institute, 2006; see also Human Rights Watch, 2001).

Attitudes towards sexual minorities
In Hong Kong, homosexuality has been decriminalised since 1991 and has been removed from the Chinese Diagnostic Manual of Mental Disorders since 2001 (Chan, 2008). Nonetheless, some Hong Kong medical professionals are still of the view that homosexuality is pathological. That is, gay and lesbian individuals have been perceived to be suffering from a pathological problem for no reason other than their sexual orientation. In a 2009 survey of 425 medical students from the University of Hong Kong, most respondents had fairly negative attitudes towards gay men and lesbians (Kan et al, 2009). Similarly, a survey was conducted among a sample of 462 Chinese social work students from three Hong Kong government-funded universities accredited by the Hong Kong Social Workers Registration Board for institutional training of practitioners in Hong Kong. Again, unfavourable attitudes towards lesbians and gay men were reported (Kwok et al, 2013). Among the five personal variables included in that study (sex, year of study at the university, religious affiliation, experience of volunteering services, and attendance on a course relating to sexual diversity), religious affiliation contributed the most in predicting differences in attitudes towards lesbians and gay men. Specifically, those in the study with Christian beliefs reported more negative attitudes towards lesbians and gay men than those without any religious affiliation. Other variables such as sex and extent of contact with homosexuals were also shown to have an impact on these unfavourable attitudes towards homosexuals. Those who were male (compared with their female counterparts) and who had no contact with sexual minorities (compared with those who had this kind of experience) reported more unfavourable attitudes towards sexual minorities.

In a comparative study in which 231 lesbians from Hong Kong and 199 lesbians from mainland China were interviewed, Chow & Cheng (2010) reported that lesbians were far more likely to be open about their sexual orientation with their female counterparts) and who had no contact with sexual minorities (compared with those who had this kind of experience) reported more unfavourable attitudes towards sexual minorities. This paper briefly reviews the legal and cultural context and notes in particular the situation in schools.

References

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interpersonal relationships if they did so (such as being completely rejected by their parents).

**Legislative context**

In 2009, the government of Hong Kong initiated a public consultation about a proposal to include lesbian and gay couples within the ambit of the Amended Domestic Violence Ordinance. After a number of hot debates among stakeholders, this Ordinance was eventually amended as the Domestic and Cohabitation Relationships Violence Ordinance (chapter 189) in 2010.

Despite these changes, which signified a more accepting attitude towards sexual minorities, to date there is still a lack of formal legislation on the protection of this group. Without institutional protection against discrimination for lesbians and gay men, negative labelling will persist. For at least some years to come, lesbians and gay men in Hong Kong are likely to remain subject to discrimination and social exclusion; civil rights relating to marriage, adoption and public services are unlikely to be granted. Nowadays, enactment of the Anti-Discrimination Ordinance on sexual orientation is still receiving considerable opposition from a number of Christian groups, with an argument that homosexuality is sinful. Due to the political power of these religious groups, the full inclusion of gay men and lesbians into Hong Kong society continues to be a difficult task.

**Sexual minorities at Hong Kong schools**

The negative attitudes towards lesbians and gay men are referred to as ‘homophobia’ and ‘heterosexism’. The former term has been used widely to describe anti-homosexual responses through attitude, prejudice, fear as well as intolerance. Heterosexism is the ideological system that denies, denigrates and stigmatises any non-heterosexual form of behaviour, identity, relationship or community. In a study by Kwok et al. (2012), young lesbian and gay students at school reported that their mental health had suffered (for example through depression and isolation) due to internalised homophobia and school heterosexism. The authors were of the opinion that the social exclusion of lesbian and gay students from their mainstream peers was likely due to school counsellors’ heterosexuality and lack of training; this was compounded by the lack of school anti-bullying policies and a heterosexist school curriculum. The authors recommended that mental health practitioners, such as counsellors, review their code of practice. Ethical principles addressing the potential damage caused to lesbian and gay service users incurred by ‘homophobic’ thought within the schools counselling services should be stipulated clearly and explicitly in a handbook guiding professional practice. Moreover, the authors also asked for training and supervision for school counsellors in issues of sexual diversity, to increase their awareness of possible prejudicial attitudes towards lesbian and gay clients. As such, counsellors would be in a better position to overcome prejudice in the provision of quality services to sexual minority clients.

**Concluding remarks**

As lesbians and gay men are recipients of prejudice from the public, they are burdened with stress, a poor quality of life and diminished self-identity. Stereotyping and discrimination are core obstacles for them to achieve important life goals (such as obtaining competitive employment, and living independently in a safe and comfortable home). As lesbians and gay men are living in heterosexual societies, ‘coming out’ (admitting that they are homosexuals) is pivotal for their personal growth and development (as it signifies self-recognition and self-assurance) (Corrigan et al, 2009). Unfortunately, in a fairly conservative society like Hong Kong, it needs a lot of courage to make such a decision. In the past few years, several Hong Kong artists and politicians have publicly stated that they are in an intimate relationship with a same-sex partner. An intention behind the action was to fight for fairer treatment from society regarding their sexual orientation. However, to our knowledge, there is still no concrete plan (and certainly no time line) from the government of Hong Kong on legislation against discrimination relating to issues of sexual diversity. Perhaps, in Hong Kong society, to promote equal opportunities among people with diverse sexual orientation, education and publicity could be two useful channels for nurturing greater acceptance and mutual respect.

**References**


HEALTH AND HOMOSEXUALITY
Sources of anxiety about (and among) sexual minorities in Africa
Marc Epprecht

Hostility towards ‘homosexuality’ in Africa has been much in the news in the past few years. Or rather, to be more accurate, we should say that opposition to sexual minority rights, and fear of or anxiety about people whose sexuality or gender identity does not conform to a narrow band of heterosexual norms, have generated heated debate and controversy. The extremism and crudity of such sentiments in Uganda have attracted particular notoriety in the Western media. There were spelling errors, for example, along with provision for the death penalty in the original proposed Anti-Homosexuality Bill in that country. But many other places on the continent have witnessed an apparent increase in incidents of hateful rhetoric, legislation and vigilantism against sexual minorities and their allies. The range of countries is so broad – predominantly Muslim, mostly Christian, highly urbanised, mostly rural, politically left-leaning, leaning to the right, ruled by generals, ruled by a democratically elected woman, formerly French, formerly British, never colonised, and so on – that it is tempting to speculate that a pan-African psychopathology is somehow in play.

This ‘African homophobia’ flies in the face of global human rights conventions, as well as public health best practices and sound economic development. The paper reviews areas of progress as well as the broad economic and cultural contexts for the experiences of African sexual minorities.

Areas of progress
The appearance of ‘African homophobia’, however, like earlier models of ‘African sexuality’, can be deceiving. For instance, the media focus on high-profile cases obscures significant, quieter progress towards human rights for sexual minorities. South Africa is a well-known success story in that regard. Since 1996, its progressive constitution has led to numerous legal victories, including the right to same-sex marriage. South Africa also co-sponsored the successful United Nations Human Rights Council resolution in 2011 to include sexual orientation among its list of categories to be protected from torture and other forms of abuse or discrimination. Numerous African states have accepted the need to target men who have sex with men for education and human rights protection as a public health priority, albeit sometimes in language that is discreet to the point of indecipherability (Epprecht, 2012).

The economic context
Much of the anxiety expressed or implicit in the homophobic rhetoric, and indeed felt by African lesbians, gays, bisexuals, trans-sexual and inter-sexed (lgbti) people themselves, arises not from African culture per se, but from the stresses and strains of globalisation. In a growing number of African countries the majority of the population now live in cities and have ready access to the global media and social networks. People for the most part worry less about ancestral spirits and rituals than about how to feed themselves and their families. The rich, after all, are getting richer and the poor poorer, following the logic of the neo-liberal structural adjustment policies that have prevailed in Africa since the 1980s. The most outspoken African homophobes thus have a lot in common with leaders elsewhere in the world seeking scapegoats for three decades of broad economic policy failure and the consequent social breakdown. In that sense, they have more in common with the far right in the USA than with traditional Africa. Indeed, they are in some cases directly allied with – and generously funded by – prominent US neo-conservatives, including proponents of discredited ‘ex-gay’ or ‘conversion’ therapy (Kaoma, 2012).

For African lgbti people, the main underlying psychological stresses can be found in the very modern circumstances in which they typically find themselves, and with which lgbti people elsewhere are also familiar: worry about health, what
to wear, hooking up, falling in love, drinking too much, holding on to a job, ‘normal’ police corruption and brutality, paying the mobile phone bill and so forth. All the usual issues that swirl around sexual orientation and identity are, however, exacerbated by the flood of images and expectations coming into Africa from the foreign media, activists, donors and immigration officials. African lgbti people often find themselves having to perform ‘real gayness’ to international audiences if, for example, they hope to achieve refugee status in high-income countries or funding from donors (Massaquoi, 2013). However, the economic crisis in so much of Africa today lends a utopian glow to the West, which can lead to deeply alienating and disillusioning experiences if asylum is granted.

That noted, not even the most cosmopolitan, ‘globalised gay’ Africans can entirely escape inherited ideas about spirituality, family, gender, and ethnic, national and African or racial identity. These create some tensions specific to Africa. People in the West should be alert and sensitive to these if they hope to be good allies in the struggle for sexual minority rights.

A pan-African perspective

Of course, in any discussion of the situation across a continent, allowance has to be made for many exceptions and local specificities.

Family is very important to African lgbti people. Extended family across generations was a fundamental building block of African culture, religion and politics, and it is explicitly enshrined as such in the African Charter on Human and Peoples’ Rights. The transition from adolescence to social adulthood required a man to become (or be thought to become) a father, a woman to become a mother; the transition to respected elder required grandchildren. This building block has been seriously eroded by the effects of political upheaval, war, migration, consumerism and Western ideas about individual identity and the nuclear family. However, no one should doubt that the supports, moral obligations, romance and companionship of extended family ties remain strong, irrespective of individuals’ sexuality. In the absence of any semblance of welfare state, moreover, children continue to be valued (indeed, are imperative in many cases) for social security. This is even more so these days, when adult children all too frequently die before their parents, leaving the latter to raise the grandchildren.

The pressure to have children can also be intense from siblings. The practice of bride-price, by which the family of the groom pays gifts to the bride’s family, is still widespread. A woman who comes out as a lesbian and refuses marriage may, by forgoing bride-price, endanger her brothers’ hopes for marriage through the recycling of cash, cattle or other goods that she would normally be expected to bring to her family.

Homosociality is a powerful norm. This is most obvious in Muslim-majority societies, where males and females cannot pray together, let alone play, travel or work in each other’s company outside often tightly supervised situations. But it applies widely across the continent. Boys and girls are mostly still socialised into strongly divergent gender roles and same-sex friendships continue to be valued as the only acceptable form of true friendship. Presumed heterosexual male–male and female–female friend relationships may be emotionally intimate and include an amount of physical touching (holding hands, sleeping together) that often surprises visitors from the West. Such relationships are preserved in part by denying the homosexual potential, and are obviously threatened by the admission that one or both may develop (and have the legal right to) a sexual attraction. Fear of losing that rich aspect of the culture, and its powerful presumption of innocence, may partly explain the intensity of feeling that is sometimes expressed against sexual minorities.

Sexuality has a metaphysical, even occult aspect in many people’s minds. Long before the establishment of police forces, social stability was maintained in much of Africa by the watchful eye of neighbours and family. Standing unseen behind those eyes were ancestors and other spirits who might intervene in the lives of the living. Sexuality, being such a powerful force among the living, was and remains one of the ways to connect to the spirit world. Hence, to maintain or to break taboos against specific sexual relationships or acts is to attract the attention of the spirits for good or evil. A prevalent stereotype today is that gays and lesbians are richer than ‘normal folks’, not only because they prostitute themselves to Westerners but also because their sex acts are a kind of sorcery that evokes wealth from bad-minded spirits. Rumours abound about certain political leaders and ethnic groups: how really do they maintain their power in face of the odds against them?

Colonialism

A staple of homophobic rhetoric is that the Europeans and Arabs introduced homosexuality during the slave-trading or colonial eras. This is not true in any substantive way, as numerous scholars have shown, myself included (Murray & Roscoe, 1998; Epprecht, 2006; Gaudio, 2009). It is true, however, that colonial rule introduced institutions like prisons and boarding schools, and abetted the rapid growth of cities. These in turn gave rise to new forms of sexual relationship among Africans. Some of these, including prostitution and prison rape, have a deservedly bad reputation among the respectable majority and it is sometimes difficult for people to disaggregate that history of abuse or exploitation from loving, mutual, consenting relationships.

Christian missionaries, backed by select readings of scripture and bowdlerised psychological theory, meanwhile propagated an ideology that equated self-control over sexual desire with modernity or civilisation. Heterosexual monogamy became a marker of self-discipline and fitness to rule, however much breached in practice. The
generation of African politicians who claimed independence imbued this ideology quite deeply, as it suited their political objectives. Some, like Robert Mugabe, are still in power today. In other cases, however, post-colonial disappointments with corrupt and compromising leaders have fuelled a competition for souls (and political influence) between new evangelical churches and Muslim brotherhoods or Islamist movements. Branding themselves with ever more dogmatic and simplistic interpretations of the faith, they are driving the cult of intolerance in places hitherto famous for easy-going and generous spirituality (Mali and Senegal, for example).

National pride and homonationalism

Many African LGBTI people are offended and ashamed by the antics of their homophobic leaders, and motivated to fight them through the courts, the media, the arts and political mobilisation with other civil society groups. Let me simply mention Nkabinde (2008), Muholi (2011), Tamale (2011) and Ekine & Abbas (2013) among dozens of impressive examples of quite courageous activism and scholarship. Many, however, are also offended by and resentful of the language sometimes encountered in Western media on the issues. Cyberspace (blogs, Twitter, Facebook) is alive with statements that generalise about ‘African homophobia’. People in Kenya rightly take offence when they are lumped together with Uganda (or farther afield) in blanket denunciations of their lack of civilisation compared with, say, the former colonial powers. Such language, which Indian scholar Jasbir Puar has called ‘homonationalism’ (Puar, 2008), makes it easy for politicians to equate gay-bashing with patriotism, and conveniently distract attention from elites’ collusion with hated economic adjustment.

Imported ideas and pressures from the West have unquestionably played a role in shaping attitudes towards non-normative sexuality in Africa. I have mentioned the Christian, bourgeois cult of respectability, ‘scientific homophobia’, ill- advised economic policies, aggressive promotion of ‘ex-gay’ and other homophobic ideology by Americans, and condescending homonationalist campaigns. There are likely others, especially when we include Islam in our understanding of ‘the West’ – an association made by many Africans. But let us not overstate this external element and ignore or deny indigenous sources of homophobias (plural). After all, some of the most intolerant speech today comes from the Ethiopian Orthodox and Coptic churches, both of which significantly pre-date established Christianity in the West. Their current stand clearly derives from a different mix of factors than the crass opportunism of politicians in Nigeria, wounded patriotism in Zimbabwe or any among the other motivating anxieties discussed above.

Conclusion

The complex factors shaping the debates around sexual minority rights, the mixed history of the West in conjuring cultures of intolerance, and the wide range of experiences of African LGBTI people (including many good ones, loving ones, politically successful ones, let us not forget!) all need to be acknowledged as we move towards global best practices. Personally, I am optimistic that we are indeed moving in that direction, however fitfully. But I also acknowledge that it is a dangerous time, with a high risk of fundamentalist or other backlash. We shall need allies to get through it, and sensitivity to local anxieties can surely only help to achieve that goal.

References


Australia and the USA, two high-income countries within the increasingly divergent Anglo-Saxon tradition, provide the focus of this issue’s thoughtful and stylistically diverse mental health law profiles. An emerging question in this series is whether law primarily aimed at protecting the civil liberties of people with a mental disorder may have reached its high point. With the economic crisis, the continuing influence of neo-liberal economics, the global retreat of the welfare state and the rise in the numbers of older people, neglect rather than coercion may be the more pressing issue. Kirkby and Henderson suggest that, in Australia, more emphasis should be put on ensuring access to good-quality, evidence-based treatment, and this position seems to be echoed to some extent in the USA, according to Vitacco and Degroot. The latter authors write in favour of community treatment orders, while the former refer to evidence seriously questioning their effectiveness or superiority in terms of service use, social functioning and quality of life. An interesting issue raised in the Kirkby and Henderson review is the increasing contribution of private/independent practitioners in the provision of compulsory mental healthcare and this, in Australia at least, appears to be related to the greater use of community treatment orders.

Since 1959 the key developments in Australian mental health legislation have concerned the review processes by tribunals, with some jurisdictions taking a more legalistic approach, such as legal representation at all tribunal hearings, while others make this optional, at the discretion and expense of the patient. With the shift to community care, community treatment orders have been introduced, reflecting the most common and preferred locus of long-term care. Guardianship acts are commonly invoked, for example for the management of financial affairs and typically run in parallel with mental health acts (MHAs). Dementia-related aged care is also supported by guardianship acts. Criminal justice and mental impairment acts typically provide for insanity defences and admissions to forensic secure mental health units.

A development of particular interest in Australia is the shift of an increasing proportion of care and treatment under MHAs to private practice. Under the universal coverage of the federally funded Medicare rebate scheme, private general practitioners, private psychiatrists and, on a limited basis, private psychologists, combined, outweigh the public mental health system. Historically these groups played a minor role in the care of ‘involuntary’ patients but they are moving to centre stage as the emphasis on community treatment increases.

Personality disorder is rarely mentioned in Australian mental health legislation, except where solely antisocial behaviour or antisocial personality is exempted from the definition of mental illness. In principle, individuals with personality disorder(s) are judged against the same criteria for mental illness and risk of harm as others are. Some legislation sets out standards of care, although more commonly services seek to warrant these by accreditation processes. Advance directives, decision-making capacity (including capacity to consent to treatment) and access to advocacy are three topical issues exercising the minds of policymakers and drafting committees. These are areas where Australia has a generally progressive approach to mental health law, reflective of international trends in human rights. Responsibility for most legislation is vested in the six States and two Territories, a total of eight jurisdictions, such that at any given time several new mental health acts are in preparation. In addition there is a model mental health act that promotes common standards. Transfer of orders between jurisdictions relies on Memoranda of Understanding between them, and is patchy.

State and Territory legislation is generally cognisant of international treaty obligations, which are themselves the preserve of the Federal Parliament and legislature. UK legislation has had a key influence in Australia, the 1959 Mental Health Act in particular, with its strong emphasis on voluntary hospitalisation, prefacing deinstitutionalisation.

Australia’s mental health legislation

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that are relevant to the whole of health and indeed beyond, not just mental health, although Australia does not have overarching legislation, such as the UK’s Mental Capacity Act 2005, to refer to.

Mental health acts and compulsory treatment

There is a model mental health act that promotes common standards (National Working Group on Mental Health Policy, 1994). Typically, MHAs define mental illness in terms of abnormalities of cognition, mood and behaviour, with exemptions such as political beliefs and gender orientation. They regulate all civil involuntary admissions, based on risk to self or others and, variably, to health.

Applications and recommendations for involuntary treatment are made by doctors, but the issue has to be decided by mental health tribunals or guardianship boards, although in some jurisdictions family may provide substitute consent to treatment. Discharge from compulsory treatment orders is by treating doctors or tribunal. The principle of least restrictive care applies. Standard tribunal review periods and processes for requesting ad hoc reviews and appeals are explicit, and similar provisions apply to renewals of orders. ‘Special treatments’ are regulated, including psychosurgery and electroconvulsive therapy (ECT), the latter in terms of standards and consent, the former (seldom used) with compulsory tribunal oversight.

Services for asylum seekers

Over the past decade, controversy has surrounded the mental health problems of asylum seekers in detention centres, often in remote parts of Australia. MHAs are subordinate to the Immigration Act. Recent contracts between host states and detention providers have included specific requirements to provide mental health services and clear guidelines regarding clinical authority where individuals come under MHA orders.

Comparative research

With multiple jurisdictions, comparative studies of the outcomes of different authorisation and review processes might well be undertaken, for example regarding the different experiences of those subject to MHA orders, or mitigation of harm to self or others. However, such comparative research within Australia is conspicuous by its absence. One systematic review seeking to determine whether compulsory treatment orders bring any benefit to patients concluded that they brought no significant difference in service use, social functioning or quality of life compared with standard care (Kisely et al., 2011). This was based on two trials in the USA.

A valuable overview of the situation in Australia and New Zealand has been provided by McSherry & Wilson (2011) in light of the Convention on the Rights of Persons with Disabilities. Gray et al. (2010) compared Australian and Canadian legislation and found significant philosophical differences regarding the purpose of involuntary admission. They noted that Australian MHAs have a relatively strong treatment focus.

Community scrutiny, rights of carers and access to treatment

Community scrutiny of mental health law has increased substantially. Consumerism is well developed and valued in Australia. Legislation and explanatory materials are available online. Community views are sought and typically represented at the table in reviews or development of legislation. Non-governmental organisations (NGOs) also have an important say.

Venkataraman & McSherry (2010) have examined the introduction of legislative provisions promoting the rights of carers; they noted the new Scottish system of ‘named persons’ and other recent provisions enabling access to information and more involvement in decision-making. Clinicians are aware of the need to reconcile the provision of evidence of impairment to a tribunal while at the same time not damaging their relationship with the patient, who is usually present at the hearing. Tribunals repeatedly insist that they be presented with explicit evidence of mental illness. As elsewhere, there seems to be no way to resolve this.

There is some interest in subsuming mental healthcare within the general law concerning consent to care or determinations of competence. MHAs have not led to improved treatment resources. Some authors believe that ‘the priority for future research lies in exploring the factors which enhance treatment access and outcomes for the mentally ill rather than debating the shape or content of mental health law’ (Carney, 2007).

An increasing emphasis on right to treatment and an associated widening of criteria to include prevention of deterioration of health is driving the application of MHAs to cover non-custodial community-based care, aimed at maintaining the patient’s place in the community. This is in marked contrast to the historical use of MHAs to sanction compulsory admissions to asylums, removing the patient from the community.

This demonstrates that MHAs are malleable instruments, particularly when they are tuned to the voices of a range of stakeholders and are also subject to a robust parliamentary process in debating any changes to legislation. Modern communications are also playing a role, widening consultative processes, improving access to legislation and facilitating the business processes associated with statutory reviews by tribunals. Although the language of legislation retains arcane aspects, the workings of mental health laws are becoming less mysterious through greater transparency, and less authoritarian through participation and communication.

Contribution to health outcomes

Arguably, mental health law has progressed faster than our understanding of the health outcomes of its implementation. In Australia, reflecting global

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Civil commitment standards in the USA have undergone dramatic changes over the past 50 years. The relevant statutes have largely focused on treatment, but how this treatment has been administered and the placement of individuals undergoing commitment have been dynamic. There have also been changes in commitment as it relates to sexual offenders and individuals deemed not competent to proceed to trial. As legislatures strive to find a balance between mandated treatment and civil liberties, changing standards of commitment provide opportunities for scholarship and research.

Civil commitment, a mechanism for mandating treatment due to dangerousness, is one of the most contentious areas of mental health law. In the USA the contentiousness is related to the often precarious balance of protecting the civil liberties of an individual with a mental illness versus protecting society from potentially violent individuals. The government has a right under *pares patriae* to protect individuals who are unable to care for themselves or are a danger to themselves; in addition, the government has authority under police power to protect society. When properly done, these two apparently orthogonal ideas can work harmoniously, and both the rights of the individual and the protection of society will be safeguarded. This paper reviews several issues related to the civil commitment process in the USA, including laws and due process, recent developments in civil commitment and treatment issues in civil commitment.

**Civil commitment law, dangerousness and due process**

Civil commitment laws have recently undergone greater scrutiny as they are viewed as a potential prophylactic to violence in the wake of mass killings at Virginia Tech University in Blacksburg, Virginia, a political event in Tucson, Arizona, and a shooting at an elementary school in Newtown, Connecticut. This was especially evident in the case of Seung-Hui Cho, who underwent a civil commitment hearing prior to the murders of 32 people at Virginia Tech. During that hearing it was decided that Cho did not meet the criteria for civil commitment because he was deemed not ‘imminently dangerous’ (Pfeffer, 2008). Likewise, there is evidence that Jared Lee Loughner, who killed 6 and injured 14 more in Tucson, Arizona, would be assessed accordingly.

**References**


has a significant mental illness requiring treatment (Winter, 2012). Unfortunately, these events have continued to perpetuate negative stereotypes, although the actual relationship between mental illness and violence is relatively slight (Elbogen & Johnson, 2009).

The early laws authorising civil commitment were not predicated on dangerousness; instead, states could commit people to an in-patient facility for treatment if they had a mental illness and were good candidates for in-patient care. Such commitments generally relied on the opinion of one mental health professional. Behaviours that would qualify an individual for commitment included mild forms of mental illness and even behaviours that might be considered only annoyances. With the deinstitutionalisation of the 1960s, civil commitment laws began relying on imminent dangerousness. Imminent dangerousness standards are geared towards the use of governmental powers to protect the public from dangerous individuals with mental illness, but have been criticised as unnecessarily narrow, in that few individuals (only the most impaired) qualify for treatment under them.

Early commitment laws involved few due process rights. Individuals did not have a right to cross-examine witnesses, present their own rebuttal witnesses or petition for release. In the landmark case of Lessard v. Schmidt, Alberta Lessard was civilly committed because of her ‘mental illness’. Lessard, on her own accord, hired an attorney and argued that allowing for detention up to 145 days without a hearing was a violation of her civil liberties. In the United States District Court for Eastern Wisconsin, Lessard prevailed on numerous grounds, including that individuals undergoing civil commitment proceedings should be afforded basic due process rights and that in order for the state to prevail in a civil commitment hearing there needed to be a finding of dangerousness.

Although limited to Wisconsin, other states soon attached due process rights to civil commitment proceedings. Notably, the Supreme Court of the United States in Baxstrom v. R.E. Herold ruled that prisoners in the New York correctional system referred for commitment at the time of their discharge were entitled to a jury hearing to protect their due process rights. The case of O'Connor v. Donaldson exemplified the rights of the individual as the Supreme Court ruled that a hospital was not allowed to detain a non-dangerous person with a mental illness who could survive independently or with available help. This decision underscored the notion of least restrictive placement, especially with an individual who was deemed not dangerous to self or others. Finally, in Addington v. Texas, the United States Supreme Court spoke directly to the issue of burden of proof and evidentiary standards related to civil commitment and proposed that the minimum evidentiary requirement for commitment was ‘clear and convincing evidence’; however, states would be free to adopt the more stringent ‘beyond a reasonable doubt’ criterion.

Recent changes in the construct of civil commitment

In recent years, civil commitment standards again have changed as two classes of individuals have garnered attention: individuals committed after a legal finding of not competent to stand trial and sex offenders civilly committed after serving prison sentences but still deemed to be a danger to others. In Kansas v. Hendricks, the United States Supreme Court held that a Kansas law authorising the civil commitment of sex offenders, for the ostensible purpose of providing them with treatment in order to prevent future sex offences, was constitutional. These civil commitment laws, now enacted in several states, are typically referred to as ‘sexually violent persons’ or ‘sexually violent predator’ (SVP) acts and allow the state to commit individuals, providing the individual is judged to remain sexually dangerous. Three things are noteworthy regarding these laws. First, they are highly controversial, with arguments about their constitutionality and the high cost to taxpayers. Second, as elucidated in Kansas v. Crane, states have wide latitude in defining mental illness under these laws. Third, the concept of dangerousness is not narrowly construed, as it has expanded in terms of both imminence and behaviour.

States have needed to develop innovative strategies to manage individuals deemed not competent to proceed to trial and committed as in-patients due to dangerousness. Rooted in the landmark case of Jackson v. Indiana, which placed limits on the time allowed for the commitment of an incompetent defendant, states have routinely struggled with individuals committed for competency restoration. This is especially true if the individual is found not competent to proceed to trial and not likely to be restored. Unfortunately, the criteria elucidated in the Jackson case are often not employed (Hoge, 2010). Legislatures must continue to balance the rights of the individual found not competent to proceed to trial and community safety.

Civil commitment and treatment

The purpose of civil commitment is to provide treatment, with the goal of reducing risk, whether that involves risk to self, violence to others, or recidivism specific to sexual offences. Legislatures have several options for administering commitment laws. For example, the creation of out-patient civil commitment laws represents a vital paradigm shift in mandated treatment. Out-patient commitment has the dual advantage of protecting individual liberties in the context of mandated treatment. Out-patient commitment law has the dual advantage of protecting individual liberties in the context of mandated treatment (Erickson et al, 2005). By providing an alternative to in-patient commitment, states save money, treat persistent mental illnesses with community-based programmes and minimise problems associated with the non-treatment of mental illness. A prime example of the move to out-patient commitment in New York occurred after an individual with a chronic mental illness pushed Kendra Webdale in front of a subway train, leading to her death. This
led to the creation of Kendra’s law (Appelbaum, 2005).

Conclusions
Civil commitment laws continue to evolve, with changing standards in mental healthcare often spurred by tragic events that bring the nexus between violence and mental illness into our living rooms. There appear to be two certainties regarding civil commitment standards in the USA. First, commitment laws will remain controversial and contentious as states try to strike a balance between rights and safeguards. Second, there are likely to be further changes in civil commitment standards with the advent of new treatments and, unfortunately, further acts of high-profile violence.

References

Addington v. Texas, 441, U.S. 418 (1979)
Jackson v. Indiana, 406 U.S. 715 (1972)
O’Connor v. Donaldson, 422 U.S. 563 (1975)

The cross-cultural sensitivity of the Strengths and Difficulties Questionnaire (SDQ): a comparative analysis of Gujarati and British children
Manasi Kumar1 PhD CPsychol and Peter Fonagy PhD FBA2

The purpose of this study was to investigate whether the Strengths and Difficulties Questionnaire (SDQ) may be considered a reliable measure of child behaviour, social functioning and adjustment in an Indian Gujarati context. The sample comprised 351 children who were classified as coming from a ‘poverty’ or ‘non-poverty’ background. The means and standard deviations for the SDQ total and five behavioural scales, as rated by children themselves, were first calculated for the entire Gujarati sample, then for the poverty and non-poverty subgroups. The SDQ did prove to be an appropriate measure for behavioural assessment. Its cross-cultural sensitivity was ascertained by comparing it against a British normative population. Small effect sizes were seen in the Emotional subscale scores and scores for total difficulties, and medium and large effect sizes on the Prosocial and Peer subscales, respectively, with greater difficulties experienced by the Indian Gujarati sample than their British counterparts.

The main aim of the present study was to find the prevalence and distribution of behavioural problems using the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) in a sample of school-aged Gujarati children in order to identify socio-emotional patterns and adjustment issues. Additionally, a cross-cultural analysis compared the Gujarati sample’s scores with those from a British normative sample of children.

The SDQ has subscales (with five items per scale) covering conduct problems, hyperactivity, emotional problems, peer and prosocial behaviour; the SDQ also gives a ‘total difficulties score’ (TDS), which, along with the prosocial score, indicates strengths such as positive social skills and general resilience. It is critical to consider the cultural sensitivity of tools used for psychological testing (Birbili, 2000), especially when the population studied is different from the one in which the test was validated (Balaban, 2006). The SDQ is a brief yet comprehensive measure of a child’s socio-psychological adjustment. Its factor structure, reliability and validity, sensitivity and specificity,
and comparability with other instruments have been assessed in Britain (Goodman & Scott, 1999), Germany (Klasen et al., 2000), Bangladesh (Mullick & Goodman, 2001) and Sri Lanka (Prior et al., 2005), among other cultures.

Method
A total of 358 children aged 8–16 years were administered the SDQ, parent and self-report version. Children included in the study were selected across two districts of Gujarat, covering two cities and two townships, approximately representative of children from families across the middle to low socioeconomic spectrum. However, it is acknowledged that this not an epidemiological study but one based on a convenience sample and constrained by funding and access to the population. While the sociodemographic data were analysed for these 358 participants, it was not possible fully to score the SDQ forms for 7 children; therefore SDQ comparisons are done for a sample of 351 children. This sample was divided into ‘poverty’ (n = 248) and ‘non-poverty’ (n = 103) groups (Table 1), on the basis of whether the children had been classified as poor on the school register (a determination made by the Gujarat state government according to household income and family size). The British normative sample comprised 4228 children aged 11–15 taken from Goodman’s norms database (http://www.sdqinfo.com/UKNorm.html).

The data were collected in December 2007 and February–March 2008. The aims and procedures of the study were explained to the parents and school teachers, and subsequently students were invited to participate. The teachers enabled testing to take place in the school settings and often helped by explaining the meaning of specific words or items in the questionnaires. The first step in data collection was to seek consent from parents as well as children. Information sheets with details of the study and researchers’ contacts were distributed and once consent was given the questionnaires were distributed. The SDQ Gujarati self-report version was translated following a rigorous translation–back-translation procedure and establishment of semantic equivalence. The SDQ self-report versions in English and the newly translated Gujarati version were administered to children mostly at various schools and occasionally at homes.

The research was approved by the research ethics committee at University College London (UCL) and was part of the first author’s doctoral work conducted at UCL (2005–10).

Results and discussion
Rates of adjustment difficulties in Gujarati children
In this Gujarati sample, the SDQ indicated that 17.4% of the children had clinically significant emotional distress or behavioural problems, that is, were categorised as ‘abnormal’ on the TDS, while none of the children fell within the ‘borderline’ band and the other 82.6% of the sample recorded scores in the normal range (Table 2). On the Emotional, Conduct, Hyperactivity, Peer and Prosocial subscales less than 10% of the sample were in the ‘abnormal’ band.

In the TDS, Conduct, Hyperactivity and Peer subscale scores there were differences between the poverty and non-poverty groups. The data also pointed towards general adjustment problems and emotional turbulence experienced by adolescents in the Indian context. Unfortunately, the influence of age on adjustment difficulties (which in fact had not been a primary area of investigation for the study) could not be retrospectively analysed because too many of the children from rural Gujarat were not aware of their exact age.

The frequency of ‘borderline’ scores for conduct problems and peer relations points towards interesting cultural dynamics. In Indian culture, deference and obedience (Shweder et al., 1987) are generally demanded from children and young people. Many children during the assessment discussed how their parents and teachers had an authoritarian stance and moralistic social ethos. It could be that the higher borderline range of distress points to a dual awareness of cultural demands and the adolescent need to resist the imposition of norms and authority. Peer relations become critical at this stage, and it is interesting that the children seemed aware of their struggle to build friendships and bonds with people their age. It could be that there is tension between the two domains of peer relations and conduct (mainly played out within the familial domain), where energies may be diverted towards one at the cost of the other.

Table 1

<table>
<thead>
<tr>
<th>Gender</th>
<th>Gujarati sample (n = 351)</th>
<th>Non-poverty subsample (n = 103)</th>
<th>Poverty subsample (n = 248)</th>
<th>χ²/τ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>180</td>
<td>56 (51.4)</td>
<td>124 (49.8)</td>
<td>0.075</td>
</tr>
<tr>
<td>Girls</td>
<td>178</td>
<td>53 (58.6)</td>
<td>125 (50.2)</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8–9</td>
<td>10</td>
<td>2 (1.8)</td>
<td>8 (3.2)</td>
<td>0.119</td>
</tr>
<tr>
<td>10–11</td>
<td>71</td>
<td>27 (24.8)</td>
<td>44 (17.7)</td>
<td></td>
</tr>
<tr>
<td>12–13</td>
<td>158</td>
<td>55 (50.5)</td>
<td>103 (41.6)</td>
<td></td>
</tr>
<tr>
<td>14–16</td>
<td>119</td>
<td>25 (22.9)</td>
<td>94 (37.8)</td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>335</td>
<td>104 (30.6)</td>
<td>231 (92.8)</td>
<td>0.880</td>
</tr>
<tr>
<td>Muslim</td>
<td>23</td>
<td>5 (6.8)</td>
<td>18 (7.2)</td>
<td></td>
</tr>
</tbody>
</table>

τ², P < 0.05.

Poverty and non-poverty group differences
The poverty group had a significantly lower proportion of children in the abnormal band (13.3% vs. 27.2%) than the non-poverty group (χ² (1, 351) = 9.762, P = 0.002); both groups reported higher levels of distress than the suggested 10% band for extreme scores. None of the groups had participants in the borderline range and the
Table 2
SDQ subscales and corresponding frequencies and percentages (across normal, borderline and abnormal SDQ score categories) for the Gujarati sample and t-test results of poverty and non-poverty groups

<table>
<thead>
<tr>
<th>SDQ subscales</th>
<th>Number (%) of children in Goodman’s behaviour bandings (Goodman, 1997)</th>
<th>Mean (s.d.) scores</th>
<th>t</th>
<th>P</th>
<th>95% CI</th>
<th>R (effect size correlation)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal</td>
<td>Borderline</td>
<td>Abnormal</td>
<td>Non-poverty</td>
<td>Poverty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(n = 103)</td>
<td>(n = 248)</td>
<td>(n = 25)</td>
<td>group</td>
<td>group</td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>302 (86.0)</td>
<td>29 (8.3)</td>
<td>20 (5.7)</td>
<td>3.23 (2.02)</td>
<td>3.26 (2.02)</td>
<td>–0.123 NS</td>
</tr>
<tr>
<td>Conduct</td>
<td>277 (78.9)</td>
<td>42 (12.0)</td>
<td>32 (9.1)</td>
<td>2.52 (1.97)</td>
<td>2.02 (1.59)</td>
<td>2.300 0.023</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>306 (87.2)</td>
<td>28 (8.0)</td>
<td>17 (4.8)</td>
<td>4.01 (1.76)</td>
<td>3.48 (1.48)</td>
<td>2.662 0.009</td>
</tr>
<tr>
<td>Peer</td>
<td>274 (78.1)</td>
<td>56 (16.0)</td>
<td>21 (6.0)</td>
<td>2.76 (2.07)</td>
<td>2.22 (1.55)</td>
<td>2.300 0.023</td>
</tr>
<tr>
<td>Prosocial</td>
<td>327 (93.2)</td>
<td>18 (5.1)</td>
<td>6 (1.7)</td>
<td>8.51 (1.61)</td>
<td>8.47 (1.64)</td>
<td>0.246 NS</td>
</tr>
<tr>
<td>TDS</td>
<td>290 (82.6)</td>
<td>0</td>
<td>61 (17.4)</td>
<td>12.50 (5.65)</td>
<td>10.98 (4.19)</td>
<td>2.466 0.015</td>
</tr>
</tbody>
</table>

*Small to **medium effect sizes.

The remainder belonged to the normal range of scores (86.7% vs. 72.8%). Small to medium effect sizes were seen in the TDS and on the Conduct, Peer and Hyperactivity subscales, with children in the poverty group scoring low or showing a tendency to under-report (it could be that they did not sufficiently understand items or got confused about the most appropriate response). In contrast, the non-poverty sample, even though their mean scores were well within the normal range, tended to report and share their difficulties actively. Of course, the two samples might differ in terms of functional literacy and socio-cognitive skills. It could be that children in the poverty group fare better despite economic constraints due to greater resilience in the face of adversity. Yet another explanation could be that psychological appraisal of one’s difficulties and mental makeup might be possible only if one has some socioeconomic stability. Therefore, despite facing more difficulties, the poverty group reported fewer problems because they could not conceptualise the enormity of their struggles, whereas the non-poverty children engaged more with psychological turmoil and stress. The fact that the poverty sample consistently reported fewer difficulties could reflect a ‘dismissing’ style of response.

Comparison with the normative British sample
Comparing the Gujarati and British samples (Table 3), the difficulties reported on the TDS and the Emotional subscale suggest that differences between the two samples could be attributable to socioeconomic disparities or gaps in educational exposure, given Goodman’s prediction for the percentage spread of psychopathology in any population (Goodman, 1997, 2002). The biggest difference can be seen on the Peer subscale, where a large effect size is reported.

The results suggest certain differences between the two national samples. The mean TDS of the Gujarati sample was higher and the small effect size conveys that, overall, the Gujarati children had experienced greater problems than their British counterparts. A significant difference between the two mean scores was seen in the Emotional subscale, where an effect size of 0.19 was found, with the Indian sample reporting higher mean difficulties than the British sample; a similar trend was seen on the Prosocial subscale, where an effect size of 0.30 was reported and the mean of the Gujarati sample was higher than that of the British sample. The higher the score on the Prosocial subscale, the lesser the difficulties and the greater the resilience, and a better mean score indicates that the Indian sample might have greater family or social support, which added to their resilience. In the case of the Peer subscale, a large effect size (0.58) was found, with the Indian sample reporting more difficulties than the British sample. The reasons for this effect have been discussed above.

Limitations and concluding comments
The study was able to compare poverty and non-poverty samples from Gujarat, and to highlight

Table 3
Effect size of difference in SDQ scores between Gujarati sample of 351 children and the British normative sample of 4228 children

<table>
<thead>
<tr>
<th>SDQ subscales</th>
<th>Gujarati sample</th>
<th>British sample</th>
<th>Cohen’s d</th>
<th>r</th>
<th>% of non-overlap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>3.2 (2.0)</td>
<td>2.8 (2.1)</td>
<td>0.19*</td>
<td>0.09</td>
<td>14.7</td>
</tr>
<tr>
<td>Conduct</td>
<td>2.2 (1.7)</td>
<td>2.2 (1.7)</td>
<td>–</td>
<td>0</td>
<td>–</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>3.6 (1.6)</td>
<td>3.8 (2.2)</td>
<td>–0.10</td>
<td>–0.05</td>
<td>–</td>
</tr>
<tr>
<td>Peer</td>
<td>2.4 (1.7)</td>
<td>1.5 (1.4)</td>
<td>0.58**</td>
<td>0.28</td>
<td>38.2</td>
</tr>
<tr>
<td>Prosocial</td>
<td>8.5 (1.6)</td>
<td>8.0 (1.7)</td>
<td>0.30**</td>
<td>0.15</td>
<td>21.3</td>
</tr>
<tr>
<td>TDS</td>
<td>11.2 (4.7)</td>
<td>10.3 (5.2)</td>
<td>0.22*</td>
<td>0.11</td>
<td>14.7</td>
</tr>
</tbody>
</table>

*** large effect size, ** medium effect size and * small effect size.
psychosocial and cultural differences between Indian and British samples. A recent study by Goodman et al. (2012) showed that the relationship between SDQ ‘caseness’ indicators and disorder rates varied substantially between populations. Cross-national differences in SDQ indicators do not necessarily reflect comparable differences in disorder rates. Therefore the results of the present study need to be interpreted with caution. What can be concluded more reliably is that, in the Indian sample, the poverty subsample faced additional challenges to the non-poverty subsample. For the Gujarati sample as a whole, the clinically significant difference found on peer relations indicates that they faced challenges in domains outside the family. A traditional family structure might help children to cope with some of these competing demands as low-income countries undergo social and economic changes.

The SDQ as a tool provides interesting and meaningful differentiations between the Indian and British poverty/non-poverty subsamples that aid the overall purpose of this study.

References

Pathways to mental healthcare in high-income and low-income countries

E. A. Sorketti,1 N. Z. Zuraida2 and M. H. Habil3

Understanding the way in which people seek care for mental disorders is important for planning services, training and referral mechanisms. Pathways to care fall broadly into three categories: via primary care physicians; via native healers; and via patient choice (patients can have direct access to mental health professionals). The pattern and nature of access to service in low-income countries are different from those in high-income countries. In many societies, deep-seated cultural beliefs on the part of patients and families about the causes of mental disorders are a major barrier to the receipt of modern psychiatric care.

Pathways to care can be defined as the contacts made during the period between onset of illness and the initiation of treatment (Rogler & Cortes, 1993). Pathway studies have been used to investigate how people use services (including time on the pathway) and the role of carers. These studies can provide information regarding the way health services perform in relation to mental healthcare (Gater et al., 2005): how primary and general healthcare services are used; whether people with mental disorders seek help outside the formal healthcare services; where and when they get treatment, and what treatment they get; whether care is delayed; the variation in and duration of pathways; and who initiates the care seeking (Gater & Goldberg, 1991; Gater et al., 1991).

Pathway studies can also be used to help monitor the effects of service developments and to compare different services. If repeated, they can allow a comparison of service functioning to be made over time. The pathways method provides detailed service utilisation data, which can map the dynamic consequences of changes in service organisation and provision. It may be used to operationalise the measurement of service accessibility (Amaddeo et al., 2001). Moreover, the pattern of patient care-seeking is important for psychiatric service and policy (Giasuddin et al., 2012).

Pathways to psychiatric care
Pathway studies have demonstrated that pathways to psychiatric care follow three patterns (Fujisawa et al., 2008).
• The first is dominated by the role of primary care physicians. Most patients first contact their general practitioner (GP), who refers them to mental health professionals; thus, GPs act as gatekeepers to psychiatric services. This pattern is typically seen in Western and in eastern European countries; the UK and Australia are examples.

• The second pattern is where native healers play an important role. This is seen, for instance, in Bali (Indonesia), India, Harare (Zimbabwe), Nigeria, Saudi Arabia and the United Arab Emirates (UAE).

• The third pattern is where patients are allowed to see any carer of their choice and are likely to have direct access to mental health professionals. This is seen in Ankara (Turkey), Lower Silesia (Poland) and Verona (Italy). In Japan, patients are allowed to access any medical facilities of their choice, and patients with psychiatric problems prefer to see physicians in general hospitals rather than private practitioners (Fujisawa et al., 2008). This is in contrast to countries in which people are supposed to see GPs before they are seen by specialists.

Direct access to mental health professionals has both advantages and disadvantages. In the Goldberg & Huxley model (Huxley, 1996), GPs are expected to function as gatekeepers, and to refer only patients with more severe illness to higher levels of specialisation. Direct access may lead to the wasteful use of the time of highly specialised professionals, as GPs are able to treat milder forms of illness. Such an arrangement would thus increase the cost of care. On the other hand, direct access to mental health professionals may shorten the period between the onset of symptoms and the patient’s arrival at mental health services for those who have milder symptoms at the beginning of their illness but who do not recover as well when treated by GPs. People with severe illnesses pass more easily through the filters to secondary professional care than do people with common mental disorders (Huxley, 1996).

International comparison of pathways to psychiatric care

The pattern and nature of access to services in low-income countries are different from those in high-income countries. However, factors other than resources may determine the receipt of care for mental disorders (Gureje & Lasebikan, 2006). These factors include: knowledge about the aetiology of the mental illness; negative attitudes to mental illness in the community; lack of awareness that the impairment is a medical problem and that there is an effective intervention for it; belief in a supernatural causation of mental illness; and fear of stigma (Gureje & Lasebikan, 2006). In contrast to findings from the high-income world, where GPs and mental health professionals are central in pathways to psychiatric care, studies from Africa have found that GPs play a less prominent role, as other help providers, such as traditional healers, are more important in this regard (Temmingh & Oosthuizen, 2008).

In one European study, a large majority of patients with mental disorders were referred directly by their GP and hospital doctors; non-medical sources of referral were minimal – 2% in Manchester and 10% in eastern Europe (Gater & Goldberg, 1991). Traditional healers did not play a major role (Gater et al., 2005). A series of studies from Africa (Erinosho, 1977; Abiodun, 1995; Bekele et al., 2009) examined pathways to care for psychiatric patients. Studies from Nigeria (Aghukwa, 2012), Ethiopia (Girma & Tesfaye, 2011) and South Africa (Burns et al., 2010) found significant delays in treatment in patients with psychiatric disorders where traditional healers were the predominant first contact. In Arab countries (Sayed et al., 1999; Al-Adawi et al., 2002; Salem et al., 2009) the majority of patients with mental disorders try home remedies and family help and consult traditional healers (faith healers, diviners and herbalists) before seeking any biomedical doctor’s help or Western treatment.

Help-seeking behaviour in many Asian countries such as India (Campion & Bhugra, 1997); Bangladesh (Giasuddin et al., 2012), Cambodia (Coton et al., 2008), Malaysia (Razali & Najib, 2000; Phang et al., 2010), Indonesia (Kurihara et al., 2006), Singapore (Chong et al., 2007) and China (Tang et al., 2007) is not different from that in Arab and African countries, where they follow the second pattern mentioned above: native healers play an important role. Duration of the untreated illness was longer in African, Arab and Asian studies than that reported in studies done in the West. The decision to consult a particular healing specialist is often taken by the family or carer. A traditional healer was consulted first because of deep-seated beliefs in the supernatural causation of mental illness and the trustworthiness of faith healers; this is a reflection of cultural beliefs relating to help-seeking (Chadda et al., 2008).

The attitudes and beliefs of family in Asian, African and Arab societies are likely to be crucial in the pathways to care. A common view is that ‘modern’ (i.e. Western) treatments are effective in curing medical (physical) illness, but are powerless against black magic or supernatural causes; in particular, psychiatrists do not have the expertise to deal with supernatural powers (Razali & Yassin, 2008). Witchcraft, charming and possession by evil spirits are regarded as common causes of illness and are the most common explanations of mental illness offered by traditional healers to their patients. Deep-seated cultural beliefs among patients and their families are a major barrier to the receipt of modern psychiatric care. People generally recognise that medical care is useful, but still believe that it does not deal with the core problem, which is spiritual.

Factors that influence help-seeking

Help-seeking is a dynamic process determined by certain social, demographic, sociocultural
and psychological factors and clinical conditions (Madianos et al., 1993). These factors influence the interpretation of psychopathological symptoms, the formation of concepts and stereotypes regarding the effectiveness of psychiatry, coping mechanisms and, finally, the decision to visit a traditional healer, physician or psychiatrist. A low level of education was found to determine directly the formation of negative attitudes to psychopathological symptoms and the use of mental health services (Madianou et al., 1986; Madianos et al., 1987). There is evidence that help-seeking for psychiatric disorders depends on the perception of illness and attitudes to treatment (Huxley, 1996). Urbanisation is associated with more frequent use of mental health services. When the ratio of psychiatrists to population is high, the individual more often turns to a psychiatrist (Shapiro et al., 1984). Symptom definition, severity of symptoms and patient response to treatment have been found to predict help-seeking behaviour (Madianos et al., 1993).

Conclusion
Understanding the way in which people seek care for mental disorders is increasingly recognised as important for planning mental health services, as well as for the provision of appropriate training and referral mechanisms between health and social care sectors.

References
Impact of religion and culture on mental disorders among Egyptians

Wafaa Gadelkarim,¹ Manal El-Maraghy² and Akeem Sule³

This review looks at the long-established customs and religious beliefs, as well as social and family structures, affecting the symptoms of psychiatric disorders among Egyptian people. It considers reactions to emotional distress and dys functionality. Some light is also shed on the healthcare system.

Cross-cultural psychiatry is concerned with the cultural and ethnic expression of mental disorders. With increasing cultural diversity, an understanding of these issues has become essential to good clinical practice.

Egypt has a mixed Muslim and Christian population, and so its centuries of traditions are coloured with strong religious beliefs; this plays an important role in the psychological make-up of its people. Nonetheless, few studies have explored its impact on mental health. Abdel-Khalek (2011) concluded that a high score for religiosity is related to good mental health and feeling happier. Religion is able to bind members of society through their shared acceptance of a set of moral beliefs and values. Indeed, this can become a part of the everyday behaviour of non-believers as well as of believers (Okasha, 2010).

Epidemiology

Egypt – by virtue of its geographical location – is central to the Arab world, is the gateway to Africa and has strong links in the Mediterranean region. It has a population of over 80 million (15–20% Christian), mostly living in the limited space along the bank of the Nile. The community structure still largely revolves around the extended family.

In spite of its wealth and natural and human resources, it is burdened by illiteracy and slow economic growth. Despite some improvement in standards of living, the average Egyptian remains poor. This, along with other factors such as lack of space to cover here, eventually led to the revolution on 25 January 2011.

An initial analysis of a recent national household survey produced an estimate for the prevalence of mental health disorder of 16.93%, which is consistent with rates found worldwide (10–20%). Mood disorders were the commonest (6.43%), followed by anxiety disorders (4.75%) and multiple disorders (4.72%). The prevalence of psychosis was around 0.2%, which is slightly lower than is commonly reported worldwide (Ghanem et al, 2009).

Profile of psychiatric presentation

Social and cultural factors affect symptom expression. Among Egyptian patients, depression is mainly manifested as agitation with somatic symptoms like poor libido, anorexia and insomnia. Patients tend to mask their affect with multiple somatic symptoms, probably because of the greater social acceptance of physical complaints.

Similarly, men with anxiety disorders mostly present with hypochondriacal complaints; in Egyptian culture ‘real men’ should not have psychological symptoms. Women, in contrast, tend to show free-floating anxiety and loss of weight (Okasha, 2004a).

Okasha (2004b) points out that the role of religious upbringing has been evident in the phenomenology of obsessive–compulsive disorder (OCD) in Egypt. The emphasis on religious rituals, in the form of repeated ablutions prior to prayer accompanied by the repetition of particular phrases, along with the warding off of blasphemous thoughts through repeated prayers could explain the high prevalence of religious obsessions and compulsions involving repetitions and cleanliness. The presentation of OCD among Egyptians is more similar to that in the Jewish population and somewhat different to that among Christian and Hindu populations. A surprising finding in Okasha’s study was that insight was mildly affected in 25% of cases, moderately affected in 50% and severely affected in 14%. This contrasted with the accepted characteristics of OCD that patients recognise the absurdity of their obsessions and compulsions.

In schizophrenia, religious delusions are frequent, in accordance with the highly religious nature of much of the Egyptian population. Often, beliefs include the intervention of supernatural beings, possession with jinn/spirits, occult forces or magic. Atallah et al (2001) studied the files of 913 Egyptian in-patients, and identified 632 sets of records that made reference to some religious or spiritual content in the patient’s delusions. In total, 309 patients had religious delusions: 44% of these patients had delusions that involved God in some way, 24% believed they were victims of black magic and 22% believed that an evil spirit controlled them. Sexual delusions were also common, owing to the suppressive social and religious environment.

Presentation with catatonia is more frequent in Egypt than in other parts of the world, probably because of the delay in seeking treatment.

When it comes to substance misuse, a study at Ain Shams University by Khalil et al (2008) referred to some figures from the 2005 report of the United Nations Office on Drugs and Crime. It indicated that drug misuse in Egypt is most problematic among men aged 20–30 years. It is less prevalent.
among women, although the incidence is on the rise; women are usually aged between 15 and 25 years when they do misuse substances. Women tend to come from higher social classes, and their preferred drugs are hypnotics and tranquillisers. The greater prevalence of substance misuse disorders among men is due to the greater freedom accorded to them.

Drug use is still regarded as a moral failure. The substances most commonly misused are cannabis preparations such as bango and hashish. Heroin misusers number around 20 000–30 000. Characteristically, in the sample under study, 64% were reported to be living with their families for most of the previous 3 years. Alcohol misuse was rare, not surprisingly, as alcohol use is prohibited by the Muslim faith. This is in contrast to the relative social acceptance of the use of cannabis, in the mistaken belief that it does not affect consciousness or judgement.

In relation to suicide, Okasha (2004a) stated that ‘feelings of hopelessness and the intention to kill oneself were not common among Muslims, for whom losing hope in the relief by God and self-inflicted death are blasphemous and punishable in the afterlife’. That also applies to the conservative Coptic Christians. There is no formal statistical documentation of suicide in Egypt, as it is a taboo subject. Most cases of suicide and attempted suicide are due to depression and personality disorders. They are mostly through drug overdose, and these patients are generally referred to hospital toxicology departments, with no or scant recording of information such as whether the overdose was accidental or intentional. Worthy of note, one of the authors went back to Cairo to practise through a volunteer programme after 15 years abroad, and observed that younger patients spoke freely about suicidal ideas and self-harm behaviour.

Child and adolescent psychiatry has attracted more attention in Egypt of late. Despite the interest in attention-deficit hyperactivity disorder (ADHD), the recent National Survey of the Prevalence of Mental Disorder excluded symptoms of ADHD at its first stage (Ghanem et al, 2009). Pervasive developmental disorders are mostly seen by paediatricians rather than psychiatrists. An Egyptian study looking at risk factors for autism (El-Baz et al, 2011) found that autism is twice as common in boys as girls (with a sex ratio of up to 5:1 for higher-functioning autism). Interestingly, 48% of the study sample were of higher social class, with parents mostly professionals. Generally speaking, parents find it hard to accept that their offspring have difficulties and consider it a failure on their part when they eventually seek help.

Mental health services in Egypt

Treatment of mental illness in Egypt was documented on the Kahum papyrus, which dates to 1900 BC. Suggestion played an important role. One of the psychotherapeutic methods used was ‘temple sleep’, which involved the use of herbs, quite possibly opium (Okasha, 2001).

Nowadays, it is widely acknowledged that the stigma attached to mental illness often leads to its underestimation and delay in seeking help. In rural Egypt, it is culturally acceptable for the family rather than the individuals themselves to make the decision to seek help; in such circumstances it is less likely that help will be sought for a woman.

In a qualitative study, Coker (2006) collected data through in-depth interviewing of 209 lay people, 106 psychiatric patients and their families, and 26 psychiatric nurses and social workers, to determine local knowledge and beliefs regarding mental illness. The study revealed the complex nature of psychiatric stigma and that Egyptians rely on religious healers as well as psychiatrists.

Mental healthcare is mainly available within the public sector. Although there are private institutions whose patients are well supported by their family networks and a multidisciplinary approach, they are not affordable for the average Egyptian. For this group, second- and third-generation antipsychotics and antidepressants are available; and treatment results match international rates.

The mental health service in the public sector was seen by Jenkins et al (2010) as underresourced in terms of infrastructure and workforce. The total number of hospital beds for a population then of around 75 million was 6156, including 788 forensic beds (i.e. one bed/12 000 population), compared with recommendations of 5–8 beds/10000 from the World Health Organization. In 2009, there were 979 registered psychiatrists, of whom 285 were consultants; however, these figures will not be accurate, because of emigration: Egypt has lost a high proportion of its psychiatrists to rich countries. Most of the specialists are concentrated in major centres.

In 2006, a public awareness project was started by the Mental Health Secretariat to address all of the above. One of the major achievements was the ratification of the Mental Health Act in May 2009 by the Egyptian Parliament, the first attempt since 1944. The new Act is now in force across all private and public centres, protecting patients’ rights. The parliamentary debates and the accompanying media attention presented an opportunity to highlight the needs of psychiatric patients and the importance of care in the community (Loza, 2010).

Conclusion

There are similarities and differences in presentation as well as management and service provision in mental health in Egypt compared with Western countries. The new spirit in post-revolution Egypt may support an improvement in mental health services.

References


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Organiser: European Psychiatric Association, World/ Psychiatric Association and School of Medicine, Aristotle University of Thessaloniki Website: http://www.phytopsy.gr
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2–5 July 2013 Royal College of Psychiatrists International Congress Edinburgh Website: Royal College of Psychiatrists
Email: info@rcpsych.ac.uk
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Website: http://www.rcpsych.ac.uk/events/conferences/internationalcongress2013.aspx
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12–13 September 2013 21st World Congress of Clinical Safety – Risk in Clinical Care Heidelberg, Germany Organiser: European Association of Risk Management in Healthcare (EARMH) and Heidelberg University Website: http://armm.org/2WCCS
24–28 September 2013 International Association for Suicide Prevention 27th World Congress 2013 Oslo, Norway Website: http://www.issp2013.org
23–26 October 2013 31st Brazilian Congress of Psychiatry – Contributions of Psychiatry to the Development of Medicine Curitiba, Parana, Brazil Website: http://www.abpp.org.br/congresso

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