



Winter 2006

**BULLETIN**  
**OF**  
**TRANSCULTURAL SPECIAL INTEREST**  
**GROUP (TSIG)**

**of**

**Royal College of Psychiatrists**

Editors: Deenesh Khoosal  
Derek Summerfield

[www.rcpsych.ac.uk/college/sig/trans.htm](http://www.rcpsych.ac.uk/college/sig/trans.htm)

**Foreword by: Prof. Kam Bhui, Chair TSIG**

Welcome to this edition of the Bulletin. We have a range of topics and themes in this issue, which will I am sure, be of interest to the members of TSIG. Transcultural Psychiatry was launched as a special area of interest through collaboration between the departments of psychiatry and anthropology at McGill University in 1956. The speciality now has importance globally, reflecting a growing awareness of the influences of culture on aetiology as well as recovery from mental illness. The specialty now embraces a broad range of research, clinical practice and academic disciplines. As interest in cultural psychiatry has grown, it has become accepted that spiritual, philosophical and critical psychiatry all raise questions about our understanding of what constitutes mental distress and what may alleviate it.

A growing interest in the mental health and wellbeing of people in the developing world has been given prominence in the College and in the World Psychiatric Association. Cultural psychiatry aims to ensure good psychiatric care in the developing world with their different resource base. My personal view is that it also needs a body of knowledge and practice that might be thought of as 'conventional psychiatry'. It is necessary to have a degree of certainty in this conventional body of knowledge to help investigate the implementation of education, policy and practice from this body of knowledge. I consider that although not opposed in functions, International Psychiatry could be applied uncritically without attention to the checks and balances proposed through cultural psychiatry critiques, through philosophical and spiritual perspectives. This Bulletin has included a range of articles from all over the world. Members are invited to participate in this important debate about the future role and validity of International Psychiatry through this Bulletin.

## **Taking People for a Ride: The Sri Lankan Example of Tsunami Affected Communities and Experience of Mental Health Interventions**

**By: Janaka Jayawickrama, Research Associate  
Disaster and Development Centre, Northumbria University**

### **Preamble**

Two years after the Asian tsunami of December 26, 2004, Agence France-Press (AFP) has reported that more than 25,000 families are still homeless in the Indonesian province of Aceh (2006, Online). According to the American Red Cross (2006, Online) there are more than 3,000 tsunami-affected families still waiting to receive support to repair or rebuild their homes in Sri Lanka. Elsewhere too, many affected communities are still waiting to receive housing support and assistance to rebuild their livelihoods and education.

According to the United Nations (Art.11 (1): 13/12/91) "everyone has a right to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions". Furthermore, the Office for the United Nations High Commissioner for Human Rights Special Rapporteur on adequate housing in a press release (online, 2000) accepts that "having a secure place to live is one of the fundamental elements for human dignity, physical and mental health and overall quality of life, which enables one's development."

How is the fact that more than 28,000 tsunami-affected families in Aceh and Sri Lanka are still in this predicament to be reconciled with the high humanitarian profile accorded the tsunami from the start? Indeed there was a near melee of activity from the large number of agencies who rushed to the region, albeit most of them without any previous experience of a country like Sri Lanka, its culture and background problems. Many came specifically to provide mental health assistance to the 'traumatised victims' of the tsunami.

But the question is: were such communities seeking mental health and psychosocial assistance framed in this way? The impressions gained from field level discussions are that they were not. They did not want counselling, instead pointing to their shattered homes and livelihoods. The children were observed to be sad, and a few with nightmares, but well functioning and keen to have their schools rebuilt. (Personal observations of the author) Surveys from the war affected northeast of the country indicate that even people who turned up at mental health centres were actually primarily concerned with issues like jobs. (Millar, 2005, p.309) Community priorities continue to be on regaining ways of life and means of livelihood. A human rights assessment conducted by Action Aid International (January 2006) pointed out that there are still major problems in land, housing, livelihoods, discrimination of women, and inequities in reconstruction programmes in tsunami-affected countries. The report notes that "a major effort is required to prevent further abuse of human rights and to correct the wrongs that characterise the first year of the tsunami response [by

all parties]” (Tsunami Response: A Human Rights Assessment, Action Aid, January 2006, p. 10).

This article explores kind of the humanitarian assistance provided in Sri Lanka by agencies after the tsunami, suggests that they missed or ignored the voices of affected communities, and critiques their claims that large numbers of people were ‘traumatised’ and in need of ‘psychosocial support.’ Using examples from Sri Lanka and elsewhere, this paper also points to unnecessary problems created for targeted communities in the process.

### **Why Psychosocial Interventions?**

The Asian tsunami prompted humanitarian agencies to divert major resources and personnel to promote programmes in keeping with dominant Western concepts of ‘mental health programmes’. This emphasis- by both international and local nongovernmental organisations (NGOs) – on Western-style counselling, psychotherapy and befriending was at the expense of programmes addressing the physical destruction wrought by the tsunami. The American Red Cross (2005, Online) explain as follows:

“The trauma associated with overwhelming experiences such as the recent tsunamis often devastates individuals. Psychosocial support interventions help people to deal with such stress-related problems and psychological traumas.

The American Red Cross provided psychosocial support experts who trained local relief workers and teachers in Maldives. These trainings are geared towards the Maldives’ culture and are modified to meet the exact needs of tsunami survivors.

The American Red Cross is also developing a similar program in Sri Lanka in coordination with the Danish Red Cross, the Sri Lankan Red Cross and the Federation.”

The following are three examples provide a stimulus to reflect on the current humanitarian discourse and its practices at global level, and to revise some of its core programming.

#### **1. Unethical directions of humanitarian aid**

There have been reports that in some southern regions of Thailand, where Muslim communities predominate, Christian aid agencies traded “aid for belief”. In return for development programmes one or other local Muslim was asked to convert to Christianity, thus justifying building a church in the village. Elsewhere, land previously owned by poor villagers has been claimed for big tourist hotels – the affected families have lost any proof of ownership to the land as a result of the tsunami. Some sources also claim that there has been a deliberate under-reporting of casualties from the tsunami. As many as 60-70 % percent of the labour force in the Thai tourism industry are migrant workers, many from Burma. Without any legal work permits this marginalised group are considered to be illegal immigrants, and have no social or legal security in Thailand. Many such migrants became casualties in the tsunami, but are kept out of official statistics in an effort to minimize the extent of the disaster and restore the

tourism industry as quickly as possible. (Aid Watch, Thailand; Report of the Conference on Good Governance, Poverty Reduction and Community Resilience with Special Session on Tsunami Recovery, Rehabilitation and Reconstruction, January 2006)

On the other hand many players were quick to get mental health teams and traumatologists to countries like Sri Lanka. Many of these 'mental health experts' were ignorant of local culture and traditions, but set up anyway counselling support groups to get affected people to share their feelings and thoughts. Many trauma groups and experts were busy preparing leaflets on 'traumatology', trading on assumptions of the universality of Western models of mind and its ailments.

One comment was: "Still there's something missing here and that's *The Whopper*<sup>1</sup>. We're getting complacent and need another really harrowing experience to jolt us out of our daze, but one that we can control and administer to large batches of depressed people on a regular basis. This is a collective homeopathic approach to tsunami trauma mitigation. If we can have a fleet of rust-bucket trawlers sent in as aid from Europe [or United States], why couldn't we get a condemned roller coaster from Coney Island? People who are feeling numb and out-of-it (i.e. traumatized) can go for a ride and scare themselves witless. Then when they come back to earth they'll be really appreciative of whatever they've got and get on with their lives. Complete cure." (Hogan, Tsunami Report, Butterfly Peace Garden, Batticaloa, 2005, personal communication)

## **2. Gaps in provision**

Some of the main gaps in Sri Lanka were: the a priori assumptions by influential agencies about what people needed; the lack of consideration of environment, particularly in land allocation and land clearance issues; the lack of coordination between the government, United Nations, local and international NGOs; a lack of cultural sensitivity that resulted in the implementation of Western models of reconstruction and rehabilitation. (December 2005: Report on the Conference on Good Governance, Poverty Reduction and Community Resilience with Special Session on Tsunami Recovery, Rehabilitation and Reconstruction, January 2006)

When local communities are spoken to, they are quick to explain their experiences after the tsunami, and how they were handled by the various organisations. "We are fishermen and we need space in our houses – not only to live but also to store our fishing equipment. After the tsunami we have been living in this camp, which is 12 kilometres away from the coast and in this place for reconstruction. When the international agency came and started building a housing scheme, we realised that they are building flats, which is not suitable to us. But when we try to explain this to the foreigners who are building this scheme, they looked at us as if we were aliens from another planet. What are

---

<sup>1</sup> Impression of scepticism by the author of the communication; *the Whopper* sandwich is the signature product sold by the international fast-food restaurant chain Burger King. (Wikipedia, 2006, <http://en.wikipedia.org/wiki/Whopper>)

we supposed to do?” (Experience of a fishing community in the East, direct discussion with the author, October 2005)

According to the Human Rights Commission (December, 2005; Report on the Conference on Good Governance, Poverty Reduction and Community Resilience with Special Session on Tsunami Recovery, Rehabilitation and Reconstruction, January 2006), there were many broken promises and unjust practices by the Sri Lankan government and by international agencies in relation to the distribution of food relief, rebuilding of houses, and in livelihood-related assistance. Often food aid either did not reach intended beneficiaries or the wrong amounts were distributed. In some cases the only food aid reaching affected communities was flour, which is not widely used in Sri Lankan cooking. This was to a certain extent done deliberately to oblige communities to sell the flour on the local market for a low price. Many people unaffected by the tsunami received aid such as money and immediate livelihood assets from donors, while others who had been seriously affected received nothing. There were many complaints about government housing regulations, the way these were applied, and about categorisations of the degree of damage to houses. Everyone with a damaged house got 100,000 Sri Lankan rupees whether one window was broken or the whole roof missing.

“The question then arises whether this can be justified based on the knowledge that the international community through a great act of generosity has given this money and that the donations have been raised in the name of the suffering victims from the tsunami. The answer to this question is no. This money should be given to the affected people of Sri Lanka and they should be given the opportunity to decide how they can best benefit from them. In other words, this money belongs to the people. Any attempt to exploit these resources in a manner that goes against the interest of the affected people should be considered as a criminal act.” (People’s Planning Commission, Sri Lanka, 2005; Report on the Conference on Good Governance, Poverty Reduction and Community Resilience with Special Session on Tsunami Recovery, Rehabilitation and Reconstruction, January 2006, p 33)

### **3. Loss of place**

The tsunami provided an unexpected opportunity for big commercial organisations to gain new points of access to prime coastal strips in Sri Lanka, India, Indonesia and Thailand. Though affected communities are still complaining about living in welfare centres, most hotels and businesses managed to re-build their buildings and to impinge on community owned lands within three months of the tsunami.

“I came to the village the day after the tsunami to look for my children but the guards had already put a fence up. I begged them to let me in but they said it was their land and they would be building a hotel. They held their guns and said that, if I didn’t go, I would join those who died in the tsunami. We have lost our families, now we are having our homes stolen too.” Daeng, Laem Pom Village, Thailand (Tsunami Response: A Human Rights Assessment, Action Aid, January 2006, p.15)

Other communities are losing their lands and resources because of unduly slow responses by government and humanitarian agencies to reconstruction and rehabilitation. “We are now living in this camp nearly a year. Our camp is about 8 kilometres away from the coast. Being fishermen we cannot do our jobs. This place is so difficult to live; for sixty families we have one barrel of water, seven toilets and small rooms to live. The officials from the agency are treating us like bunch of animals. On top of all these things, our lands are being taken by a company to build a hotel complex. Where should we go and what can we do?” Community Leader Kalutara District, Sri Lanka (Direct discussion with the author, October, 2005)

### **The real problem**

The above examples show that unplanned and unco-ordinated humanitarian assistance without a clear vision may create as much distress as the disaster. To categorise affected communities as ‘traumatised’ and in need of psychological or psychosocial support – and on the basis of assumptions that owe nothing to the voices of the people themselves – is to miss important opportunities to provide humanitarian assistance that will be valued by recipients. In a World Health Organisation commentary entitled ‘What exactly is emergency or disaster mental health?’, Summerfield (2005) points out that: “ it is a category fallacy to assume that, just because similar phenomena can be identified in various settings worldwide, they mean the same thing everywhere. Even the best back-translation methodologies cannot solve the problem, as it is not one of translation between languages but of translation between worlds. We need to remember that the Western mental health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal.” (p.76-77)

Korn (1997, p2) points-out that “the body is to spirit like the land is to its people—the ground of life force. However there are predators — people, governments, and corporations, who exert power over others in order to take the resources of people and their lands. And because of their intimate interconnection, taking the land destroys a people, just as taking the rituals and ways of life destroys the land. The invasion of “development” disconnects people from their land and its plentitude of resources just as rape leaves an individual disconnected from her and others and in somatic, psychic and spiritual pain.”

These humanistic reflections suggest that humanitarian intervention without the involvement of targeted communities in planning, implementation, management, monitoring and evaluation will not succeed, and may cause additional problems. What can such interventions achieve if at the same time the recipients are losing access to land, water, natural resources and social services upon which viable life depends?

The Sunday Observer, a major English-language newspaper in Sri Lanka, published a story on January 9, 2005 entitled “Responding to the aftermath of the tsunami: Counselling with caution”. The following criticisms were included:

It is simplistic to view all those who have survived the tsunami as mere helpless victims who are unable to act on their environment or situation

Sometimes it is the humanitarian aid community and wider public, not the affected communities themselves, who (wrongly) attach high importance to individual counselling and therapy. Refugee camp settings often breach principles regarding the involvement of local people in decision-making processes affecting their future; the re-making of communities needs local ownership and participation

In contrast, the staff of the Postgraduate Diploma in Counselling and Psychosocial Work, Faculty of Graduate Studies, University of Colombo, describe their work in Eastern Sri Lanka. (Kalayjian, 2005, Online). "The Mental Health Outreach Project (MHOP), a non-profit disaster relief organization of the Association for Disaster and Mass Trauma Studies headquartered in New York and spearheaded by Dr. Anie Kalayjian, Treasurer of the United Nations Committee on Human Rights and Adjunct Professor of Psychology at Fordham University, organized teams of professional volunteers to go to Sri Lanka to deliver psychological first aid, training, and counselling to the tsunami victims.

The team provided empathy and validation to the survivors in groups as well as individually. It was reinforced that they did the best they could in circumstances above and beyond their control. Many team members were sad and overwhelmed as they heard survivors, one after the other, tell their stories of courage, creativity, survival, and loss. People expressed multiple losses that they could not endure. MHOP provides daily group therapy, individual therapy, and art therapy with the children, and desensitization groups for those fearing the sea and the return to their homes near the sea."

What Kalayjian is explaining in her article is the Western biomedical view of trauma as an individual experience to be understood within a framework of pathology, and there has been a vast output of published studies along these lines- as examples, see Coddington, (1972); Vogel & Vernberg, (1993) and Joseph, Williams & Yule (1995). They argue that disaster-affected communities, including children, often have negative outcomes- including ill health, loss of motivation, and depression. Psychotherapy, as practiced in Western countries, largely takes the form of an individual client consulting a therapist. In Africa, Asia and other developing country settings, most therapeutic approaches draw in other family members and often the wider community. When it comes to responding to the effects of disaster and violence, Western style psychotherapy can have the effect of 'individualising' the suffering of the person involved. This might be inappropriate and indeed harmful in more socio-centric societies, where recovery for the individual is tied up with recovery for the wider community (Shweder et al., 1982). This is also true for refugees and asylum-seekers from non-Western cultures who are living in Western countries. (Meucke, 1992)

However, other commentators like Summerfield, Hume and Toser (1991, 1992, 2000) argue that medical models are limited because they do not embody a socialised view of mental health. Exposure to a massive disaster, and its aftermath, is not generally a private experience. It is in a social setting that the

experienced that need help reveal themselves and that the processes that determine how victims become survivors (as the majority does) are played out over time. Jones (2004, p. 4) a child psychiatrist who worked in Bosnia after the war argues that “after meeting children in Gorazde I came to believe that humanitarian programmes and mental health professionals were approaching the subject of war trauma and children [including communities] from the wrong direction.”

What the Westernised mental health field doesn't understand is that in most non-Western cultures, the individual would not exist without their community. As Martin-Baro (1990) explains, the identity of an individual is based on their harmonious relationships with family and community. A woman in Sri Lanka is not simply an individual person; her identity comes through being a mother, daughter, wife, grandmother and through her work as farmer or teacher. So too for men, children, youth, the elderly, as well as people with a disability. This identity provides them with a place in the world, including respect and honour.

Galappatti (2005, p.65-69) notes that: “professional and traditional approaches to healing and well-being are sometimes incompatible. There are real concerns about linking approaches that espouse wholly different values and frameworks. The tension between an imperative for professional intervention and a commitment to folk/indigenous perspectives has, in the case of this tsunami disaster, been resolved yet again in the favour of the former”. Traditional and indigenous perspectives, and the local experience and knowledge they carry, are not treated as important and useful. The danger of this is that the community's ability to laugh, smile and celebrate life (as most disaster-affected communities can still do all over the world) may be undermined. Inappropriate interventions which afford only a passive role, awaiting a cure delivered by outside ‘experts’ or inside ‘experts’ who totally depends on Western knowledge, may contribute to the creation of truly helpless and vulnerable individuals, dependent on humanitarian assistance. In addition, because Western mental health models involve expertise, training and a new language of medicotherapeutics, local articulations and understandings of distress, and its antidotes, are devalued. This may have the effect of undermining some of the local, time-honoured processes that offer protection at a time of crisis.

It is at present unclear just how much the humanitarian sector involved in psychosocial and mental health programmes is taking these issues seriously.

### **Discussion and Conclusions**

Any given five-year-old child now knows the terms NGO and UN in Sri Lanka. According to the Human Rights Commission of Sri Lanka, NGOs are the fastest growing industry in Sri Lanka, with 2-3 new groups registering daily. (People's Planning Commission, Sri Lanka, 2005; Report on the Conference on Good Governance, Poverty Reduction and Community Resilience with Special Session on Tsunami Recovery, Rehabilitation and Reconstruction, December, 2005), Disaster relief efforts, while predominantly well intentioned, tend to overlap, lack cohesive coordination and often step on culturally sensitive “landmines”. Villagers in the coast complain of flashy Land Cruisers roaring through towns with logos or organization names plastered all over the vehicle

and its passengers, leaving behind people weary of survey questions and empty promises.

However, Korn (1997, p.9) argues, “The antidote to traumatic stress is to take control – control of land, resources, political and economic structures.” The community reaction to the tsunami was in accordance with what it meant to them, and has come to mean Generating these meanings is an activity that is socially, politically, culturally, economically and often environmentally framed. This is what counts. Since all experience is relative, there will be no easy prediction of how disaster affected communities prioritise their recovery, rehabilitation and reconstruction. Most natural or human-made disasters worldwide do not take place as an isolated act but in the context of the destruction and terrorisation of whole communities. Survivors must focus outwards on their damaged social worlds, not inwards on their allegedly damaged psyches.

The real question is that whether the mental health “experts” and the trauma industry are ready to acknowledge the dubious validity of Western psychiatric and psychological formulations, and Western-style counselling, in settings like Sri Lanka. Such importations are as much aspects of the globalisation of the Western social, cultural and economic order as are MTV, Macintosh, and McDonald's (Binion, 1999, online).

#### References:

- Action Aid International (2006) *Tsunami Response: A Human Rights Assessment*, Action Aid International
- Alternative Evolutions; Working Group on Good Governance, Poverty Reduction and Community Resilience (2005). *Report on the Conference on Good Governance, Poverty Reduction and Community Resilience with Special Session on Tsunami Recovery, Rehabilitation and Reconstruction*, Green Movement of Sri Lanka.
- Agence France-Press (2006) *25,000 families still homeless in tsunami-ravaged Aceh*, World/Asia-Pacific, Online; [http://www.chinadaily.com.cn/world/2006-12/07/content\\_752613.htm](http://www.chinadaily.com.cn/world/2006-12/07/content_752613.htm)
- American Red Cross (2006) *American Red Cross Provides US \$10 Million to Boost Tsunami Housing in Sri Lanka*, Press Room, Online: [http://www.redcross.org/pressrelease/0,1077,0\\_314\\_5896,00.html](http://www.redcross.org/pressrelease/0,1077,0_314_5896,00.html)
- American Red Cross (2005) *Psychosocial experts train local relief workers to counsel tsunami survivors*, Tsunami Recovery and Relief Efforts, Online; <http://www.redcross.org/tsunamirelief/mentalhealth/>
- Binion, C, (1999) *Brave new McWorld*, Online Journal of Politics and More, [http://members.fortunecity.com/editor\\_oj/Media/Binion121600/binion121600.html](http://members.fortunecity.com/editor_oj/Media/Binion121600/binion121600.html)
- Coddington, R.D. (1972). *The significance of life events as etiologic factors in the diseases of children - II A study of a normal population*, Journal of Psychosomatic Research, 16, 205-213
- Galappatti, A (2005) *Psychosocial work in the aftermath of the tsunami: challenges for service provision in Batticaloa, Eastern Sri Lanka*, Intervention, Vol 3, No 1, 65-69.
- Hogan, P. (2005), *Tsunami Report, Z – Doc 1, Butterfly Peace Garden, Batticaloa* Personal Communication
- Jones, Lynne, (2004) *Then they started shooting: growing up in wartime Bosnia*, Harvard University Press
- Joseph, S., Williams, R. & Yule, W. (1995) *Psychosocial perspectives on post-traumatic stress*, Clinical Psychology Review, 15 (6), 515-544
- Kalayjian, A (2005) *Sri Lanka: Post Tsunami Mental Health Outreach Project - Lessons Learned*, International, Online; [http://www.psichi.org/pubs/articles/article\\_494.asp](http://www.psichi.org/pubs/articles/article_494.asp)
- Korn, L. (1997). *Community Trauma and Development*, University College, Dublin and the Center for World Indigenous Studies, Olympia WA., U.S.A.

- Martin-Baro, I. (1990) War and the psychosocial trauma of Salvadoran children, Posthumous presentation to the Annual Meeting of the American Psychological Association, Boston
- Muecke M. A (1992) *New paradigms for refugee health problems*. Soc. Sci. Med. 35:515,
- Office for the United Nations High Commissioner for Human Rights (2000) *Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context*, Press Release, online: <http://www.ohchr.org/english/issues/housing/index.htm>
- Shweder, R. A. and Bourne, E. J. (1982) *Does the concept of the person vary cross-culturally?* In Marsella, A. J. and White, G. M. (eds) *Cultural Conceptions of Mental Health and Therapy*, 111. D. Reidal Publishing Company, Dordrecht
- Sunday Observer (2005) *Responding to the aftermath of the tsunami: Counselling with caution*, Features, Online; <http://www.sundayobserver.lk/2005/01/09/fea28.html>
- Summerfield, D. (2005) *What exactly is emergency or disaster "mental health"?* Bulletin of the World Health Organisation, 83(1), 76-77
- Summerfield, D., & Hume, F. (1992) *War and posttraumatic stress disorder: The question of social context*. Journal of Nervous and Mental Disease, 181, 522
- Summerfield, D., & Toser, L. (1991) *"Low intensity" war and mental trauma in Nicaragua: A Study in a rural community*. Medicine and War, 7:84-99
- Vogel, J.M., & Vernberg, E.M. (1993). Part 1: Children's psychological responses to disasters. *Journal of Clinical Child Psychology*, 22 (4), 464-484

<b>REFLECTION ON UNCERTAINTY</b>
----------------------------------

**By: Jack Piachaud, Psychiatrist**  
**Medical Foundation for Care of Victims of Torture**

As a semi-retired psychiatrist, unable to resist escape from the hurly burly but not quite sufficiently committed to idleness, one day a week at the Medical Foundation for Care of Victims of Torture, London, creates enough intellectual challenge and stress to allow other days seem relatively calm. Her is a little reflection on some of the complexities.

The week or two before Christmas I found myself wishing my parents a Happy Christmas. Now, as most were asylum-seeking non Christians, I knew that they had no means to be festive, nor would they be concerned about Christ's Mass, yet I wanted to wish them well in my own terms. I found myself explaining that this was our tradition, even explaining about trees, present, turkey dinners and the like; some might say this was falling into the Britishness agenda.

In our interactions with our patients what do we say about ourselves? Is it a flat reflective dispassionate discourse? Definitely not! I find myself in frequent discussion with my patients about myself, this country, about our culture, our family structures, urban isolation, street culture, the way we greet and look at each other, how our society is structured. Part of therapy is comparative ethnography for they also have a need to tell me about where they have come from. There is good and bad in both places.

What do we understand about each other across our divides of language, experience and culture? What is most alienating? Their personal experience of torture and physical abuse, their experience of uncertainty and treacherous travel or their isolation, deprivation, failure of expectation and hope in the UK? What do

I represent to them, this psychiatrist, obviously comfortably middle class, part of the UK establishment, asking them detailed personal questions; of course I have to explain myself.

Are there universals to the human experience? How can my explanations make sense to this man from Afghanistan who has lived all his life in war or this man from Iran, tortured for his beliefs. We edge towards some mutual explanation of each other, over a period of time. Who knows, but I like to believe there are universals; that we can speak meaningfully across divides; that empathic connection has less to do with culture than with some other aspect of identity. Some people remain distant and hidden whether from Kinshasa or Kings Lynn.

So what am I doing there? A question I frequently ask. Perhaps justifying my existence through a voyeurism which brings a vicarious attachment to a reality that I am deeply fearful of, that of violence and the capacity for human destruction. But on brighter days I hope I am doing something practical to help a small number of people and participating in a broader debate about how human beings should treat each other.

At present I find writing psychiatric medico-legal reports too problematic, except for patients I have been seeing from some time and whose experiences and difficulties have begun to take some real shape for me. Before, I used to ask for three appointments to explore the mental state and its connections with the story being brought but still found that insufficient. I blame my background in learning disability, a specialty where social context is integral, but here with people seeking asylum there is a complete dislocation from any social context relevant to the report being sought, though clearly not from the mental state. The asylum experience is enough to cause mental disorder in most.

There is also the problem of truth but is this really a medical matter? If you were sailing through desperate seas and came across shipwrecked people floundering in the water, as you reach out a hand is your first question: are you an honest, truthful fellow?

So right now I am doing psychiatric case work; sorting out housing and benefits, with reports to solicitors, to NASS and to whoever it might be useful to write to. We address sadness and intrusive memories along the way and always the encouragement to go to college to learn English and to live day by day.

Do I believe in short term interventions? Where does CBT and EMDR fit into this? If I felt my patients were coming primarily to get these therapies then these would be helpful, but most have multiple problems with the underlay of cultural divide. It takes several meetings before I believe they understand what I mean by CBT and how it might help. Then I use such techniques or refer to others but this is not the end of our work together; and I do agree with the call for more research on this matter [1].

But I have another problem with it which may be described as the Layard-Wilkinson dilemma. Two eminent social science researchers, one an economist and the other an epidemiologist, have both spent the last twenty or more years

trying to understand how people feel about their lives and their society and what might influence this [2,3]. Richard Layard, the economist, has concluded that the general state of unhappiness/ depression needs a huge increase in mental health professionals and a good dose of CBT; billions of pounds will be saved for Industry and the Exchequer. Wilkinson, on the other hand identifies a lot of evidence that this unhappiness/depression arises from the economic inequalities in our society; the greater the inequality in a society then the greater the degree of mental ill-health and our society has been becoming progressively more unequal since the 1950's.

Working with refugees and displaced people whether here in the UK or in camps and urban squalor elsewhere in the world, brings to the fore the political dimension to this; the impact of inequality, of being at the bottom of the social pile, of seeing no hope for restitution.

We are at a cross roads, not unlike that of the 19<sup>th</sup> century when the discoveries of public health laid the foundations for sanitation, shelter and clean water. Our knowledge now of the connections between social order, culture, inequality, justice and mental health are such that we could pursue a programme of public mental health which has at its root a respect for other human beings and the need to meet their basic physical and psychological needs. Should we say "Sod the sanitation let's give them anti-diarrhoeals" and "Sod social justice, let's give them CBT", or is there a possibility of provoking the necessary political change?

**References:**

- Basoglu M. Rehabilitation of traumatised refugees and survivors of torture. BMJ 2006;333;1230-31.
- Layard R. Mental Health: Britain's biggest social problem? London: HMSO, Cabinet Office; 2005. Available at: [http://www.cabinetoffice.gov.uk/strategy/downloads/files/mh\\_layard.pdf](http://www.cabinetoffice.gov.uk/strategy/downloads/files/mh_layard.pdf)
- Wilkinson R. The Impact of Inequality. London: Routledge; 2006

**IN SUPPORT OF A BRITISH CAMPAIGN FOR MEDICAL BOYCOTT OF ISRAEL**

**By: Dr Derek Summerfield, Hon Senior Lecturer, Institute of Psychiatry (London); Teaching Associate Refugee Studies Centre, University of Oxford.**

It has been frequently argued that doctors have a duty not only to their patients, but wider obligations not to ignore the social and political factors that operate to create suffering and poor health in the first place. Dr Vivienne Nathanson of the BMA International Committee wrote in a BMJ editorial a few years ago that it was a doctor's duty to speak out. With this in mind, please read the article below. I appeal to those interested to contact me.

In 2004 nearly 60 of the most prominent academic, cultural and professional associations and trade unions in the Occupied Palestinian Territories, including the Federation of Unions of Palestinian Universities' Professors and Employees

and the umbrella organisation of Palestinian Non Governmental Associations, came together to issue an appeal to colleagues in the international community. This was for a comprehensive and consistent boycott of all Israeli academic and cultural institutions as a contribution to the struggle to end Israel's occupation, colonisation and system of apartheid, with its concomitant breaches of international conventions of human rights, its refusal to accept UN resolutions or rulings of the International Court, and its persistent suppression of Palestinian academic freedom. In November this year a broad range of health sector organisations and individual doctors in Gaza made the same call.

What of the medical profession? If I may start with a short personal account. I have been involved with the Occupied Territories for the past 14 years. One struggle, alongside Palestinian and Israeli colleagues, was to highlight the use of torture by Israel as an instrument of state policy, which Amnesty International and a slew of reputable international and regional human rights organisations had long since proved was institutionalised in the interrogation suites handling large numbers of Palestinian detainees every year. Amnesty also concluded that the role being played by Israeli doctors working in and around these interrogation suites were fundamentally at odds with medical ethics. Amnesty, and others, who approached the Israeli Medical association (IMA) to urge them to take a stand were consistently rebuffed. This too has been my experience when I published articles in mainstream medical journals- notable the British Medical Journal and the Lancet. In response to one of these, published in the Lancet, the longstanding president of the IMA Dr Y Blachar actually justified the use of "moderate physical pressure", the euphemism in Israel for torture!

The moral position and strategic line taken over many years by the IMA was well captured by a remark made by Professor Eran Dolev, then IMA Head of Ethics (yes, Ethics!) in an interview in 1999 with a visiting delegation from the Medical Foundation for the Care of Victims of Torture, London (for whom I was principal psychiatrist for 9 years). Prof Dolev stated that that "a couple of broken fingers" during the interrogation of Palestinians was worthwhile for the information it might garner. When I published this in the Journal of the Royal Society of Medicine, verified by those present at the interview, Dr Blachar defended Prof Dolev.

Two years earlier I had written to Prof Dolev after a human rights conference in Gaza, when an Israeli physician had told me that a medical colleague had confessed to her that he had removed the intravenous drip from the arm of a seriously ill Palestinian prisoner, and told the man that if he wanted to live, he should co-operate with his interrogators. I asked Dolev to investigate but he never replied, even after reminders.

When challenged in the BMJ or Lancet, the IMA continues to maintain that there are no medical ethical concerns arising out of the conduct of the Israeli army towards the Palestinian general population. Dr Blachar routinely labels me and others as motivated by anti-Israel bias and by anti-semitism. Indeed after my BMJ review of Oct 2004 he wrote at bmj.com: " the lies and hatred he spews are reminiscent of some of the worst forms of anti-semitism ever espoused", a response that directs open contempt towards the mass of documentation in the public domain- all from distinguished international human rights organisations like

Amnesty International and Human Rights Watch, and regional ones like B'Tselem in Israel and Health, Development, Information, and Policy Institute in the Occupied West Bank- that I am citing. Yet the Israeli Defence force (IDF) operates in a climate of near total impunity, with disproportionate force directed implacably towards the civilian population: over 4000 shot dead in the last 6 years, including around 850 children. These are truly shocking numbers, and ever growing. The recently published testimonies of the 'Breaking the Silence' group of ex-soldiers attest to shoot-to-kill policies that give the lie to official mantras about minimising the risk to civilians.

A veritable mass of documentation now confirms systematic and ongoing violations of the medical ethical sections of the Fourth Geneva Convention. There have been many deaths of seriously ill Palestinians, and of newborn infants, at army checkpoints because they were denied access to hospital. Ambulance drivers on duty are interrogated, searched, threatened, humiliated and assaulted. Wounded men have been taken from ambulances at checkpoints and sent directly to prison, and on other occasions Israeli soldiers have commandeered ambulances as transport. On numerous occasions the clearly marked ambulances of the Palestinian Red Crescent society have been hit by IDF gunfire. 2 years ago the IDF fired missiles at Bethlehem psychiatric hospital, which had 250 patients and 75 staff present at the time. There was extensive damage and staff were arrested. Clearly identified medical clinics, including those run by the aid agency Medecins Sans Frontieres, have been hit by gunfire. The International Committee of the Red Cross and other aid agencies have at times been forced to limit their work in the West Bank because of threats to staff and attacks on vehicles by the IDF. There has been wilful hampering of the distribution of food aid, on which half a million people are now dependent. A study by Johns Hopkins and Al Quds Universities found that 20% of Palestinian children under 5 years old were anaemic and 22% malnourished. The IDF has also wilfully destroyed water supplies, electric power and other elements of the public health infrastructure. The continued building of the apartheid wall and fence has hugely damaged the coherence of the Palestinian health system.

Life in Gaza has become almost impossible this year, following Israeli blockade of goods (including medical supplies) and of funds to pay public sector workers. Patients died in Gaza hospitals as a direct consequence- for example, because dialysis fluids and chemotherapeutic drugs had run out. The commendable Israeli doctors of Physicians for Human Rights Israel (PHRI) published a new report on Gaza-, which they call a "humanitarian disaster"- based on a field trip last September. They quote Jan Egeland, the UN Under Secretary-General for Humanitarian Affairs as saying "there is no hope" in Gaza. Women and children now present with palpable malnutrition, barely supplied hospitals are overwhelmed by casualties, many with terrible wounds, from continued Israeli bombing (nearly 300 dead, including 66 children, since June- and virtually unreported), and their morgues fill up with charcoaled and shredded bodies. There are interruptions of power supplies due to Israeli bombing and hospitals must save their generators for operating theatres and emergency rooms only, patients with medical problems for which there is no treatment in Gaza are "condemned to a slow death" (as the report puts it) because they are blocked from seeking treatment in Egypt or Israel, and even people who were not initially

critically ill have died from blood loss after Israeli bombing because the movement of ambulances and medical staff requires permission from the IDF- often not forthcoming or very delayed.

It has been evident for several years that Palestinian medical staff on duty could not count on the immunity afforded them by the Fourth Geneva Convention. They too are targets. To give just 2 recent examples, 11 people were killed (murdered, more precisely) on June 13 when 2 missiles were delivered from the air at a car. This included 2 paramedics who ran from a nearby medical facility to attend to the victims of the first missile and were killed by the second, which appears to have been fired despite a clear view of the scene. The Red Cross has been highlighting the most recent instance, on November 5, when 2 paramedics wearing "clearly marked fluorescent jackets" were shot dead when they got out of an ambulance (with siren and flashing lights) to evacuate wounded civilians.

Similar and persistent violations of the Fourth Geneva Convention have been widely reported following Israel's grotesque attack and destruction of a neighbouring sovereign state, Lebanon, with over 1000 civilians murdered. Reportedly as many as one million cluster bombs, which are essentially anti-personnel devices aimed at civilians, were seeded in defiance of the Geneva Convention, prompting UN protests. Israel has now admitted that phosphorus containing weapons were used, also illegal against civilians, as they were in their 1982 invasion of Lebanon (the journalist Robert Fisk remembers seeing the bodies of 2 children re-igniting when taken out of the mortuary). Furthermore, the Secretary of the European Committee on Radiation Risk states that samples taken from blast sites suggest that uranium- based bombs may have been used as well. Hospitals were hit and UK newspapers carried photographs of a wrecked ambulance, with the point of entry of the missile at the very centre of the large Red Cross painted on the roof. The Lancet carried a letter on September 2 in which a physician in the Family Medicine Programme, American University of Beirut, describes his attempts to recruit colleagues to help staff a hospital several kilometres away. He reports that volunteers did not want to go in an ambulance "because such vehicles were targets".

The IMA have been entirely silent about such events, as they have always been. This is in fundamental breach of their mandate- not least as members of the World Medical Association (WMA), the official international body charged with overseeing medical ethics. Incredibly, IMA President Blachar has been for 3 years Chair of Council of the WMA!

Bar PHRI, a minority group, these grave matters have attracted no condemnation from the medical profession in Israel, with their academic bases in Israeli medical schools and research institutes. Many of these doctors have international academic connections, and unlike their Palestinian counterparts their movements are unhampered, their respectability and probity unchallenged. Why is this? Indeed Israeli universities have maintained a studied silence about the tremendous harm done over many years to the capacity of their Palestinian counterparts to run as universities should run: the restrictions, the prolonged closures, the damage to property, the campus incursions by the IDF, the arbitrary expulsions, the harassment and shooting of students on their way to lectures.

We must sadly conclude that with honourable exceptions most doctors and medical academics are in active or passive collusion with an aggressive colonisation, with the control and, increasingly, the frank crushing of every sector of Palestinian civil society, and with a self-justifying discourse that trades on a dehumanising contempt for Palestinian as people in a different moral universe.

One central thread to the work of both Edward Said and Noam Chomsky, both truth tellers of our times, concerns the role of the academic and professional institutions of the Western world. These have seemed to embody the promise of an independent moral authority within a society, but in practice have generally acted to confer legitimacy to the dominant order and its interests. We see this starkly in Israel (though also, it might be added, in USA and UK). I might add that Noam Chomsky described the IMA to me as demonstrating “utter moral degeneration”.

So what are we to do? Firstly, repeated efforts to reach out to the IMA has been unavailing, as my own experience bears out unambiguously. Secondly, the WMA have refused to challenge the IMA; or even to acknowledge the problem. They are unmoved by the mountain of material by Amnesty and others. Indeed in a telephone conversation with me 3 years ago WMA Secretary General Delon Human defended the IMA, saying “they have been active collaborators in the WMA’s continued struggle to eradicate torture...all over the world”. This is utterly preposterous. Thirdly, British doctors might expect some action from their own association, the BMA, whose International Committee deal with ethical matters, but they have hidden behind platitudes (“we believe in education”, as if the IMA had not been making choices with its eyes open over many years). The BMA has consistently declined to challenge the IMA record at the WMA and has stressed its collegiate links with the IMA: does this refusal reflect the power of the Israeli lobby? I even appealed, via a long letter, to the recently knighted UK Chief Rabbi, Sir Jonathan Sachs, but he did not deign to reply.

We do not lightly call for stigmatisation via an academic boycott but things have surely come to this. If not now, when? It was at a moment like this that calls went out (and there was considerable opposition then too) for the academic isolation of South Africa during the apartheid era. This rightly included a boycott of the medical profession for collusion of a very similar nature to what we see today in Israel. For instance, the Medical Association of South Africa was for a time suspended from membership of the WMA. On visits out there in recent years (I am South African born) I have heard it said more than once that the boycott played a distinct role in bringing the profession to its senses. As in South Africa, the Israeli medical profession, and the establishment generally, is sensitive to opinion in the Western world, not least from fellow doctors.

An academic boycott in an extreme situation is a moral and ethical imperative when all else has failed, for otherwise we are in effect turning away. It is not contrary to “academic freedom”, as some assert, but in its very spirit. Any Israeli doctor who publicly disassociates him or herself from state practice becomes part of the solution rather than part of the problem. The place to start is a boycott of the IMA, who have made their decisions with their eyes open over many years, and should be held to account for them. This is how.

## **BETEL LEAF (PAAN): TRADITIONAL VIEWS AND MODERN CHALLENGES**

**By: Dr Pradeep Rao, SHO, Leicestershire Partnership NHS Trust**

The Betel plant (piper betle) originated in Malaysia but is cultivated in India, Sri Lanka, Indonesia and other tropical countries. The fresh leaves of this plant are folded into a triangle containing various spices and ingredients and also called paan or quid. These terms are often used interchangeably. It is consumed by over 15-20 million people in India alone. The Betel Quid is a combination of betel leaf, areca nut and a paste of calcium hydroxide. Paan consumption also takes place in migrant populations in East Africa, UK and the US. (Gupta et al, 2002). Areca nut alone is chewed by an estimated 20-30% of the world's population making it the fourth most widely used psychoactive substance after nicotine, alcohol and caffeine (Gupta et al 2004).

### **Traditional views**

Sushruta, the author of one the most ancient Indian medical texts wrote that betel leaf was anti-helminthic, anti-inflammatory, antiseptic, astringent, blood-purifying, carminative, digestive and invigorating. It also cured bad breath. Sushruta believed that all these qualities were not found together even in heaven!

Vatsyana's Kamasutra suggested that "it is only after cleaning the teeth and having looked into the mirror and having eaten a tambula (paan) to render fragrance to the mouth, should a person start his day's work". Paan is described as an aphrodisiac in many traditional writings including Mahawansha (The Great Chronicle), a Buddhist document of the early history of religion in Sri Lanka. Vatsyayana included betel leaf as a "solah shringar" which is one of the 16 essential toiletries. It is also a part of religious ritual and is regularly offered to the Gods. Ancient Indian texts identify the consumption of betel leaf as one of the eight enjoyments of life together with incense, women, clothes, music, bed and food. Many works of Indian art show Paan and all the betel utensils and implements used particularly in the miniatures so popular with collectors.

The consumption of Betel leaf has great significance in Hindu wedding rituals. Paan is distributed at weddings to the guests. A special wedding custom exists in some areas in which the bride holds a Paan in her mouth and the bridegroom has to bite off his half from the other end. Betel boxes were commonly given as wedding gifts. Ascetics, widows and young persons were not permitted to have Paan possibly because of its aphrodisiac properties. There are frequent references in folklore of lovers sharing betel or offering it to each other. This is not surprising as Paan has always been associated with eroticism. The tradition of eating Paan by women was popularised by Queen Noorjehan, the mother of King Shahjehan who built the Taj Mahal. Queen Noorjehan discovered that by adding specific ingredients to Paan it gave the much prized red colour to the lips of the consumer.

## Modern challenges

Betel leaf is still used in South East Asia for treating non-healing wounds, poor appetite, fever, worms, nausea, diabetes, blood purification, anti-helminthic, maintaining clean teeth and gums and as an aphrodisiac. It is also considered to be useful in the management of skin conditions such as eczema, boils, leprosy, urticaria, dandruff and for skin discolouration.

A recent article has suggested that the aphrodisiac and other properties of Paan may be due to its antioxidant nature (Shrishailappa et al, 2004). There is however a higher incidence of oral cancer in South Asian communities in the UK which is considered to be related to chewing betel quid (Shetty et al, 1999). 80% of Bangladeshi adults use betel quid regularly (Ahmed et al, 1997). Other reports have suggested that the tobacco itself in the betel quid is carcinogenic (Chang et al, 2002). The psychoactive nature of the constituents of Paan leads to dependency. The challenge is to incorporate research findings in dispelling myth and identifying appropriate usage if appropriate.

## References:

- Ahmed, S., Rahman, A. & Hull, S. (1997) Use of betel quid and cigarettes among Bangladeshi patients in an inner-city practice: prevalence and knowledge of health effects. *British Journal of General Practice*, 47, 431-434.
- Chang, M.C., Uang, B.J., Wu, H.L., et al (2002) Inducing the cell cycle arrest and apoptosis of oral KB carcinoma cells by hydroxychavicol: Roles of glutathione and reactive oxygen species. *British Journal of Pharmacology*, 135, 619-630.
- Guha, P. (2006) Betel leaf- The neglected green gold of India. *Journal of Human Ecology*, 19(2), 87-93.
- Gupta, P.C. & Ray CS. (2004) Epidemiology of betel quid usage. *Annals of Academic Medicine of Singapore*, 33(suppl), 315-365.
- Gupta, P.C. & Warnakulasuriya K.A.A.S. (2002) Global epidemiology of areca nut use. *Addiction Biology*, 7, 77-83.
- Irani, F. (2005) An encounter with Ayurveda Aromatherapy. *Aromatherapy Journal*, 3, 29-35.
- Shetty, K.V. & Johnson, N.W. (1999) Knowledge, attitudes and beliefs of adult South Asians living in London regarding risk factors and signs for oral cancer. *Community Dental Health*, 16, 227-230.
- Shrishailappa, B., Rai, S.R. & Suresh, B. (2004) In-vitro antioxidant properties of Indian traditional paan and its ingredients. *Indian Journal of Traditional Knowledge*, 3(2), 187-191.

## Betel Nut: A Brief Introduction

**By: Dr Katherine Morton SCMO, Newham House Treatment Team**

### Introduction

Despite the worldwide use of Betel Nut, there appears to be relatively little accessible data about Betel Nut. This article outlines what betel nut is, who uses it, why, and the physical and psychiatric implications associated with its use.

## **What is Betel Nut?**

Betel nut (also known as Areca nut) is the seed of the Betel Palm (*Areca Catechu*)<sup>1</sup>. Betel nut is commonly chewed as a “package” consisting of small amounts of betel nut, lime (calcium hydroxide) paste or powder, tobacco and spices such as saffron and cardamom<sup>2,3</sup> wrapped in the vine leaf of the *Piper betle*. This is colloquially referred to as betel chew, paan, quid or wad. Chewing the package is said to evoke a sensation of wellbeing, heightened alertness and suppression of appetite. The taste is described to be subtly sweet and spicy. Chewing stimulates large amounts of saliva which is coloured red because of the ingredients. This characteristically colours the lips and gums dark red. Effects can last for up to 2-3 hours.

The active ingredients of betel nut are alkaloids and tannin<sup>4</sup>. The main alkaloid is arcolene that has stimulating parasympathetic nervous actions which induces the sensation of relaxation, stimulates salivation and reduces appetite. The alkaloids also neutralise gastric acid and these act as an astringent. Tannin also contributes to this astringency. The Piper betle leaf contains phenols that contribute to its aromatic scent and taste. It also contains eugenol which has antiseptic properties.

## **Tradition**

Chewing betel originated in South East Asia but extends from East Africa to the Pacific Islands. The custom dates back to over 2,000 years and is firmly embedded in many cultures<sup>5</sup>. Chewing betel leads to pleasant psychostimulant effects. It is also a sociable pastime and is offered and accepted as a sign of hospitality. Betel nut is considered to symbolically represent establishing communication between spiritual forces and social relationships. It has key significance in many aspects of culture including ritualistic offerings in Buddhist and Hindu ceremonies. Betel nut is also used for traditional medicinal purposes.

A betel “set” is necessary for preparing and chewing betel nut. It consists of a box, tray or basket to hold all the ingredients for chewing betel either with different compartments or individual containers. It also has a cutter for slicing the nut, a spatula for removing the lime paste and spreading it on the leaf, a spittoon and a mortar and pestle.

## **Epidemiology**

Betel nut is estimated to be used by 200-400 million people worldwide (a tenth of the world’s population) and is the fourth most commonly used psychoactive substance after caffeine, alcohol and caffeine<sup>6</sup>. It is used by men and women and spans all social classes and ages.

The traditional use of betel is increasingly confined to the elderly<sup>7</sup>. Whilst the popularity of betel nut is said to be diminishing in South Asia, its popularity has increased in India and Taiwan due to the ready availability of prepacked packages known as “pan masala” or “guthka”. Such packages are widely advertised and persuasively marketed to young people. In some parts of India, almost one-third of children and teenagers regularly chew betel products. In Taiwan, the culture of so called “Betel Nut Beauties”, (scantly clad girls selling betel by the roadside), has maintained high sales with estimates of about 9%

of the adult population, with a strong male preponderance, regularly chewing betel nut <sup>8</sup>.

Many Asians living in Europe and North America have continued the betel-chewing custom. Among Asian communities in the UK, Bangladeshis are most likely to retain this habit with estimates of 80% of adults and adolescents of Bangladeshi descent using betel <sup>9,10,11</sup>. Britain is the major importer of betel nut outside Asia<sup>12</sup>.

### **Physical Health Implications**

Betel nut consumption significantly increases the risk of oral malignancy (squamous cell carcinoma) and its precursors (leukoplakia and submucous fibrosis) <sup>13</sup>. Oral squamous cell carcinoma accounts for up to 50% of malignant tumours in South Asian countries. This relationship between betel and oral malignancy holds even when tobacco has been excluded as a confounder. Risk is related to the duration and frequency of betel use. Other conditions associated with use of areca nut include oesophageal cancer, cardiovascular disease, diabetes and asthma.

### **Mental Health Implications**

A classical dependence syndrome with difficulty abstaining, withdrawal symptoms, headache, sweating etc and further use to relieve withdrawals has been described with frequent betel use <sup>14</sup>.

The effect of Betel use has also been considered in patients with psychotic illnesses. A small study considered that betel chewing was associated with milder positive and negative symptoms <sup>15</sup>. There have also been reported cases of worsening of extrapyramidal side effects in patients maintained on depot medication. This is presumed to be secondary to the cholinergic action of the areca nut <sup>16</sup>. The use of betel is therefore not as benign as is considered by regular users and health professionals need to be aware of this in the management of patients.

### **References:**

1. [http://www.drugscope.org.uk/st\\_about.asp?file=\wip\1\11\1\1\betelnut.htm](http://www.drugscope.org.uk/st_about.asp?file=\wip\1\11\1\1\betelnut.htm)
2. [http://en.wikipedia.org/wiki/betel\\_nut](http://en.wikipedia.org/wiki/betel_nut)
3. [http://www.betelbox.com/whats\\_a\\_betelnut.htm](http://www.betelbox.com/whats_a_betelnut.htm)
4. Rooney D. Betel Chewing Traditions in South- East Asia. Oxford University Press 1993: Chap 2; p16-29
5. Rooney D. Betel Chewing Traditions in South East Asia. Oxford University Press 1993 Chap 1 and 3; p1-15 and 30-39
6. Gupta PC, Warnakulasuriya S. Global epidemiology of areca nut usage. *Addiction Biology* 2002; 7:77-83
7. Gupta PC, Ray CS Epidemiology of betel quid usage *Ann Acad med Singapore* 2004 33(Suppl): 31S-36S
8. <http://goreuters.com/printerfriendlyPopup.jhtml?type=oddlyEnoughNews&storyID=11758869>
9. Ahmed S, Rahman A, Hull S, Use of betel quid and cigarettes among Bangladeshi patients in an inner city practice: prevalence and knowledge of health effects. *Br J Gen Pract* 1997 Jul (420): 431-4
10. Bedi R, Gilthorpe MS. The prevalence of betel quid and tobacco chewing among the Bangladeshi community resident in a United Kingdom area of multiple deprivation. *Prim Dent Care* 1995; 2; 29-42

11. Farrand P, Rowe RM, Johnston A, Murdoch H. Prevalence, age of onset and demographic relationships of different areca nut habits amongst children in Tower Hamlets, London. Br Dental Journal 2001 (190) 150-154
12. <http://www.health.asiangate.com/English>
13. Warnakulasuiya S, Trivedy C, Peters T. Areca nut use: an independent risk factor for oral cancer. BMJ 2002; 324:799-800
14. Winstok AR, Trivedy CR, Warnakulasuriya KAAS, Peters TJ. A dependency syndrome related to areca nut use: some medical and psychological aspects among areca nut users in the UK. Addiction Biology 2000; 5: 173-179
15. Sullivan R, Allen J, Otto C, Tiobech J, Nero K. Effects of chewing betel nut (*Areca catechu*) on the symptoms of people with schizophrenia in Palau, Micronesia. Br J Psych (2000), 177, 174 – 178
16. Deahl M. Psychostimulant properties of betel nuts. BMJ 1987, 294, 841

## KHAT: AN OVERVIEW

**By: Avinash Hiremath, SHO, Leicestershire Partnership NHS Trust**

### **Introduction**

Khat is a herbal product consisting of leaves and shoots of the shrub *Catha Edulis*. It grows wild in countries of coastal East Africa where chewing it has been a practice for centuries with many people using this shrub to obtain its stimulant effect.

### **Patterns of use**

Khat is mainly used by people in countries where it grows. Its use has also been reported in migrant populations from these countries residing elsewhere. The majority of people chew Khat. A minority of people prepare drinks or smoke it. Its use is a social and culture based activity. There are reports of it being used to enhance religious experience, concentration and performance at work.

### **Pharmacokinetics and Pharmacodynamics**

Most of the effects of chewing Khat come from two phenylalkylamines-cathinone and cathine, which are structurally related to amphetamines. Cathinone is the most active ingredient and has been described as "natural amphetamine", producing effects by sympathomimetic and central nervous system stimulation. The euphoric effect appears shortly after chewing begins and reaches a maximum in 15-30 minutes. It ceases when the user stops chewing. It is metabolised and excreted as noradrenaline. Only 2% of it appears in urine. Biochemical methods are available to indirectly detect Khat in the urine but clinical enquiry about its use is essential. It is not clear whether chronic Khat use can lead to dependence. Development of tolerance seems unlikely. There are some reports of withdrawal symptoms including lassitude, anergia, nightmares and slight trembling.

### **Psychological effects**

Users describe an increased sense of well being, euphoria, energy, concentration, libido and work performance. After chewing ceases, they report insomnia, low mood, numbness and poor concentration. As it needs to be chewed, its intake is limited and toxic states are uncommon.

### **Psychiatric sequelae and their management**

Psychiatric effects have been reported as a consequence of consumption of larger quantities and in those who are susceptible. Both schizophreniform and manic type syndromes have been reported. These tend to remit with cessation of use. Self-harm, suicide and violence have also been reported in response to psychopathology whilst the manic symptoms usually last for about 8 hours. Depression has been reported following cessation of use. There is limited literature about the management of conditions associated with Khat use. Clinical syndromes appear to remit within a few days. If symptoms are severe or persistent, antipsychotics may be needed. There are reports of successful use of thioridazine and haloperidol but not of atypical antipsychotics.

### **Conclusion**

Khat use is a culturally accepted activity for many people originating from Coastal East Africa. Psychiatric sequelae, though reported have a low incidence and are largely self-remitting. An awareness of the possibility of its use and specific enquiry during clinical assessment is important if appropriate care is to be made available.

### **References:**

- Cox G & Rampes H. (2003) Adverse effects of khat: a review. *Advances in Psychiatric Treatment*. Vol.9, 456-463
- Khat Report (2005). UK Home Office Report. <http://www.drugs.gov.uk>

## **CONFERENCE REPORT: BEIJING 2006**

### **By: Prof. Kam Bhui, Chairperson, TSIG**

The first World Association of Cultural Psychiatry meeting in Beijing was a terrific success with over 300 participants from around the world and from every continent. The subjects traversed the emic – etic divide, and the idographic and group or population based approaches. There were active debates about systems of mental health care, suicide outcomes, clinical assessment and practice, and laws in China, US, UK, Africa, New Zealand. Intra and cross country comparisons yielded interesting patterns of similarity as well as differences in values, and in priorities, time scales and the integration of practice and policy. The rich academic programme was complemented by the cultural learning from those new to Beijing and China.

WACP encourages people from national Transcultural societies to join, and to propose activities, meetings, convergence themes to the president, Professor

Tseng. The next meeting will be in Rome in 2009 (Prof Bartocci is the organiser) and the one following will be London in 2012.

## CONFERENCE REPORT: DEPRESSION AND CULTURE

**By: Dr Adedayo Ayokynu Alabi, SHO, Leicester Partnership NHS Trust**

This year's annual conference of TSIG was held at the Royal College of Psychiatrists on 11<sup>th</sup> October 2006. It came at a time when the NHS is undergoing considerable changes, reshuffling facilities and facing the Herculean task of balancing the books. We live in a culturally diverse society with culture sensitive mental health problems. Identifying and understanding distinctive needs will affect service development and make the NHS "friendly" in a society demanding equal opportunities for all.

Dr S Jadhav, senior lecturer, (London), the first speaker discussed folk models of mental illness across cultures. He talked about the process involved in his historical and ethnographic study of depression among white Anglo-Saxon Britons. He compared illness concepts in this group with people from non-western cultures. He also highlighted perceived causes, narrative accounts of symptoms and relationship between depression and somatoform disorders between white Anglo-Saxon Britons and South Asians. The term "semen loss" (or loss of genital secretion) in culture bound syndromes was used to illustrate perceived cultural beliefs in different geographical areas. This is particularly important in the view of the high percentage of international trainees in our specialty.

The morning session ended with Dr Imran Ali, Specialist Registrar (Manchester). He shared his experiences in running a one-stop clinic for ethnic minority people in Glasgow. He looked at one year's data from Jan to Dec 2005. He looked at a total of 89 people from 12 ethnic groups. The majority were Pakistani, then Indian and Chinese. 92% were female, 7 different languages were noted. Most referrals came from GPs. Despite high attendance, and considerable patient satisfaction, further work needs to take place regarding increasing the number of front line staff, better office space and encouraging smaller ethnic groups and men to uptake services.

The afternoon session explored depression amongst Irish migrants and in Black Caribbean people living in London. Dr Gerard Leavey, epidemiologist and social scientist, provided statistics showing that Irish people are the largest immigrant group in England and Wales. They also have higher morbidity and mortality for all the major mental illnesses compared to other groups. This was surprising as they are English speaking, white and share a similar cultural identity. The relative proximity of Ireland however creates a false sense of security as this group of people did not make definitive plans to settle or return. This led to distress and the consequential emergence of mental health problems. Although the relationship between mental health problems and

migration is complex, poorly planned migration played a significant role in the development of mental illness in Irish people. It remains unclear whether experience of discrimination exacerbates depression.

Prof. Kwame McKenzie, University of Lancaster, looked at common mental disorders (CMD) in people of Caribbean origin in UK. His study showed that rates were not relatively high for people of Caribbean origin in UK. He noted that risk factors appeared to be different. Rates of depression were slightly higher whilst rates of anxiety were slightly lower for Caribbean people compared to white British. Current understanding of epidemiology of CMD does not seem to apply to ethnic minority people. It was noted that Caribbean people are less likely to see their doctor when they become ill. It is possible that the social cohesiveness brought about by adherence to religious practices for example was protective against CMD and suicide for this group of people.

This year's conference was an immense success. It highlighted cogent factors determining mental health problems across cultures and possible ways forward. The lively debate on depression and culture was fascinating and informative. I look forward to the 2007 conference.

## **FORTHCOMING EVENTS**

Psychiatry in Developing Countries. 15<sup>th</sup> – 19<sup>th</sup> March 2007  
WPA section; South Asian Forum; RCPsych South Asian Division  
Lahore, Pakistan  
Email: [Afzal.javed@ntlworld.com](mailto:Afzal.javed@ntlworld.com)

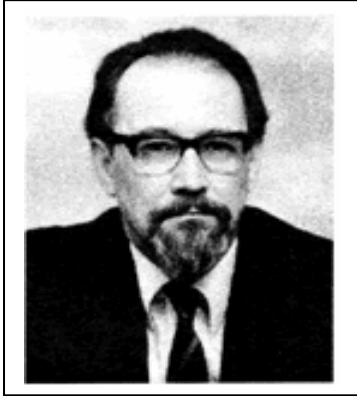
The New Era of Transcultural Psychiatry: Advancing Collaboration of East and West. 27<sup>th</sup> – 29<sup>th</sup> April 2007, Kamakura, Japan  
Conference Organiser: Dr Fumitaka Noda MD.  
Sponsors: Japanese Society of Transcultural Psychiatry. World Psychiatric Association, Transcultural Section. World Association of Cultural Psychiatry.  
Contact: [wpa@shonan-village.co.jp](mailto:wpa@shonan-village.co.jp); <http://shonan-village.co.jp>

Conference on Conflict, Mental Health and Making the Peace. 11<sup>th</sup> – 12<sup>th</sup> May 2007. Lymassol, Cyprus.  
Organised by the Royal College of Psychiatrists' European Division in collaboration with the London Institute of Psychiatry  
Contact: Dr Nathaniel Minton  
Email: [nd.minton@btinternet.com](mailto:nd.minton@btinternet.com)

Remembering, Repeating and Working Through in Psychoanalysis and Culture Today. Berlin, Germany. 25<sup>th</sup> – 28<sup>th</sup> July 2007.  
International Psychoanalytical Association Congress.  
Website: <http://www.ipa.org.uk>

## OBITUARY

### Philip Rack



Former consultant psychiatrist Bradford (b Keelby, Lincs, 27 October 1931; q Cambridge/The Royal London Hospital (1958), died from fibrosing alveolitis on 12<sup>th</sup> October 2005.

Brought up in a Quaker family Philip Rack was educated at Quaker schools, Ackworth and Bootham. He went on to Clare College, Cambridge, and The Royal London Hospital, where he became interested in neurology and psychiatry.

After training in Leeds he was appointed consultant psychiatrist at Lynfield Mount Hospital and Bradford Royal Infirmary. Here his aptitude for seeing the broader picture came to the fore. He became aware that, compared with the size of the Asian community in Bradford, the number of Asians using the psychiatric services was disproportionately small. Lunchtime seminars were initiated to increase understanding of Asian culture and improve awareness of the impact of cultural difference on mental processes and mental illness.

He was one of the first to recognize the need for a sub-specialty devoted to transcultural differences and in 1976 organised an "International Congress on Transcultural Psychiatry", which was an important milestone in this field. He served on the Race Relations Board and became a visiting specialist in Pakistan to evaluate an agrotherapy project in Lahore. His book *Race, Culture and Mental Disorder* attracted a wide readership and was translated into several foreign languages, leading to involvement with other indigenous groups, an excellent example being an invitation to address a conference of Sami people in northern Norway.

He was a lateral thinker, full of curiosity, who enjoyed provoking discussion and debate both among colleagues and at social gatherings. He could always see why and rarely why not and enabled others to realise their potential and vision.

Retirement gave him the opportunity to pursue a wide variety of interests, particularly alternative technology and ecological topics.

More than all this, however, he was a man whose chief pride was not his professional achievements or his hobbies but his family.

He faced his long drawn out final illness, with courage and composure. He leaves his wife, four children, and 10 grandchildren. **(Jenny Rack)**

*Reproduced with permission from BMJ 2006;332:493(25/2) No. 7539*

## CALL FOR PAPERS: THE ISSUE OF VALIDITY IN PSYCHIATRY

**By: Dr Derek Summerfield, Hon Senior Lecturer, Institute of Psychiatry**

In a recent review, Hollifield et al (2002) calculated that 78% of all published studies on non-Western subjects relied exclusively on Western measures of psychopathology. This suggests that culture and context can be seen as mere packaging, discarded whilst standardised methodologies (“reliability”) applied to a universal psychobiological man get at the “real” problem. Arguably, this is a form of medical imperialism, since it asserts that the Western epistemology-including models of mind and definition of personhood- underpinning psychiatric constructs can be considered definitive knowledge, universally applicable. Reliability cannot redeem studies that are invalid because they commit a category error: the assumption that because phenomena can be identified from one setting to another, they mean the same thing everywhere. Validity is the elephant in the room, which international psychiatry (as Hollifield et al showed) seeks studiously to ignore. One question is whether Western psychiatric measures can ever be turned into universally valid instruments, however much there is tinkering with criteria and translation.

We invite readers to submit papers or comments for the next issue of the Bulletin.

Hollifield, M., Warner, T., Lian, N., et al. (2002) Measuring trauma and health status in refugees: A critical review. *Journal of American Medical Association*, 288, 611-21.

## NOTICES

- TSIG Members: Please send OSCE’s and extended matching questions to Kwame McKenzie, Secretary TSIG for consideration for MRCPsych exam.
- Please ensure your email address is included on the College website, and let College know that TSIG can have access to this to facilitate communication.
- A call for applicants wishing to work with the Exec team as (a) Secretary and (b) Website editor. Applicants would be expected to be active in TSIG and have the skills to ensure the smooth running of TSIG. Please contact the Chair for information, [k.s.bhui@qmul.ac.uk](mailto:k.s.bhui@qmul.ac.uk), 0207 882 2012.

This is a publication of the Transcultural Special Interest Group. The views expressed here are not necessarily those of TSIG or the Royal College of Psychiatrists.

If you would like to contribute to the newsletter, please contact Dr D Khoosal, Brandon Unit, Gwendolen Road, Leicester, LE5 4PW.