Editors Note: Helme Najim

The revolution of technology and transport has brought Transcultural issues to the forefront of our planet. Unfortunately conflicts have arisen around the world which resulted in forced displacement of people, this unforeseen change has its impact on the mental health of people and whole societies affected by those tragedies, hence the relevance of transcultural issues.

Our transcultural psychiatry special interest group was busy this year. We managed to organise a symposium at The Royal College about psychiatry about the global impact of stigma in psychiatry, which was well attended, generated a lot of discussion and further planning for more topics and symposia.

I am pleased to announce our executive members expansion, which included different parts of the UK and around the world, who expressed their interest in taking our SIG forward with their contributions. I am always intrigued and excited by team work especially if it is coloured by the rainbow with diversities of different members around the world.

Our newsletter has been getting more evolved with a variety of articles of different fields of interests. This was due to the relentless efforts of our executive members and their very helpful and creative contributions.

Our effort to publish articles about expression of depression in different languages has been rewarded by a contribution about expression of depression in Bengali, our first one was in Arabic and this is the second, which was again a lucky coincidence to have the second letter of the alphabet. We would be pleased to receive contributions about expression of depression in other languages.

Executive members team efforts culminated by an article by Kate Wood which explored the interesting relation between Anthropology, culture and psychiatry.

Arabinda Chowdhury managed to elucidate ecopsychiatry and shed light on its practical applications.

Lena Jawad managed to report to us about her experience of psychiatric practice in Cambodia.

You would be entertained and intrigued by Ahmed Hankir style who interviewed a giant figure in transcultural psychiatry, Prof. Laurence Kirmayer who works in an authentic place which witnessed the birth of Transcultural psychiatry

As my term is coming to an end, I don’t want to make promises I will not be able to achieve and it may put my successor under pressure, for that reason, I will leave it to Dr. Shahid Latif, the new chair, to see what has been done and take their own decisions and plans forward.

I thoroughly enjoyed my role in the TPSIG over the past four years, but as any process, it is hallmarked by a beginning and an end, this makes it more interesting and less stagnant.

I would like to thank you all for your continued help and support and wish the new chair, the executive committee and the TPSIG all the best.

I hope you enjoy reading this issue and wish you more joy and fruitful contributions.
Ecopsychiatry: A new horizon of Cultural Psychiatry

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Introduction: The language of psychiatry is changing in the current century. The rapidly evolving human environment with urbanization, mechanisation, violent social disruption, displacement and migration, massive destruction of rain forests and globalization with cyber communication, the focus of positive mental health is shifting from biological ‘hypotheses’ to a psychosocial universe, so much so, that the psychosocial stress is being one all-inclusive aetiological term gaining prominence in recent medical literature. The impact of changing environment, both positive (ecosystem services) and negative (risk and hazards) and both natural or deliberate, thus offers a new contextual platform of Ecopsychiatry, that helps us to understand that how the eco-cultural issues contribute to mental health and illness. 

The term Ecopsychiatry was coined in the late 1970s by the American Psychiatric Association. Conceptually it means the application of ecological construct in the study and practice of psychiatry. Edgerton puts it as “Scientific concept describing the basic and applied relationship between living things and their environment. These are assumed, by their presence or absence, to affect mental health”. Ecosystems are the food-chain or web, community or network of living organisms that exists and work into a self-organized and complex hierarchy of pattern and interactive process. Ecosystem also provides goods and services that sustain human societies and wellbeing through the principles of biodiversity. Biodiversity is the degree of variation and pattern of different life-forms within a given ecosystem. Biodiversity is a measure of the health of the ecosystem, where greater biodiversity means greater health. Biodiversity is related with all aspects of human living, e.g., agriculture, food, water, lifestyle, social activities, economic aspects and material development of the society. Ecopsychology is the study of the mind and the synergistic relationship between environmental and personal wellbeing. Ecopsychology and environmental psychology are two interrelated disciplines which deal directly with human-nature relationships.
Hawley, an American sociologist is regarded as the pioneer in the field of human ecology. Wilkinson and O’Connor in their paper on ‘Human ecology and mental illness’ showed how the eco-psychiatric concepts gain prominence when mental health services expanded from its institutional boundaries to the community. Research in mental health, especially in child psychiatry shows how the natural environment is important for shaping developmental behaviours. The APA Task Force in 1977 formed an Ecopsychiatric Data Base and suggested the term “ecopsychiatry” to describe person-environment interactions. The task force also suggested that mental pathology should be viewed in the context of the “deviation-amplifying” or “deviation-counteracting” processes in the human eco-system.

With the advancement of technology, globalisation and rapid social growth, the science of Human Ecology encompassed a more wide conceptual framework and methodology of research. This was particularly so in outlining the interrelationship between populations and environmental resources including degradation. Gradually these linked concepts, ranging from ecosystem to evolution, evolved to reflect economic, anthropological and sociological ideas and welcomed the emerging social and environmental challenges of the modern world. Newer concepts like Ecological anthropology, Cultural Ecology, Ethnobiology, Ecopsychology, and Ecotherapy (a union between ecopsychology and psychotherapy) have considerably strengthened our insight regarding the enduring nature of the relationship between human psyche and the natural world. Ecopsychiatry is the emerging branch of mental health science which tries to corroborate the impact of environment on psychological wellbeing. Moffic has argued for Ecopsychiatry as a distinct speciality for the 20th century. Currently there is a significant focus on the ecopsychiatric perspective in the context of monumental ecological changes (both natural and man-made) globally.

In the event of modern day rapid changes in human societies with unprecedented ecological changes, the scope of Ecopsychiatry has broadened to a greater extent with far reaching consequences for mental health of the population. For all practical purposes Ecopsychiatry today encompasses the ecological specificity of the region, ecological degradation and ecological disaster (both man and nature made) including global warming and climate change - all of which have a deep impact on both physical and mental health of the
exposed population. The resultant negative impacts on social and community structure is the cause of changing cultural landscape (human modified environment) with a special impact on cultural geomorphology. These emerging concepts and scientific studies stressed the importance of culture of the environment and thus offering a new horizon to the Cultural Psychiatrist to broaden their ambit to examine the effect of environment in shaping human behaviour- both normative and abnormal. In the context of recent global scenario of climate change and worldwide distribution of war and conflict zones- these offer a new and challenging area of engagement for the cultural psychiatrist to study the dynamics of human behaviour in the midst of new environment-human interactions.

Climate change: The psychological impact of global environmental change and environmental connections with mental illness is a recent topic of public health interest in Ecopsychiatry. Climate change is considered as “...potentially the biggest global health threat of the 21st century. It is predicted to have wide-ranging impacts upon human mental health and well-being, through changes and challenges to people’s environment, socioeconomic structures and physical security”. At least three key mental health issues relating to climate change has been emphasized: direct impacts of climate change, such as extreme weather events or natural disasters, disruptions to the social, economic and environmental determinants that promote positive mental health and threat of climate change leads to emotional distress and anxiety about the future. Just an example - studies have shown that communities affected by Hurricane Katrina showed high rates of depression, domestic violence, suicide- completed (14.7 times higher) and attempt (78.6 times higher) than the community baseline and PTSD. The studies of the impact of climate change e.g., from draught affected rural Australia, found number of social issues that negatively influence mental health, viz., reduced income security and stress, social isolation, relationship strain and increased rate of suicide. The study of relationship between Eco-distress and consequent devastating psychosocial impact relating to mass-farmers’ suicides in developing countries is a new challenge to cultural psychiatry. Displacement of population due to environmental causes (flood, disaster, Tsunami or earthquake etc.); termed as ‘Environmental refugee’ is an enormous humanitarian crisis and this forced migration has tremendous negative physical and mental health impacts.
WARS AND CONFLICT ZONES: Wars including ethnopolitical conflicts is now recognized as an important contributor to varieties of psychosocial disorders in conflict affected population. Currently over 30 wars are ongoing in different parts of the world and one of the most unfortunate facts is that up to 90% casualties are civilians with increasing numbers of children and women. WHO estimated the mental morbidity from armed conflict situations as: “10% of the people who experience traumatic events will have serious mental health problems and another 10% will develop behavior that will hinder their ability to function effectively”. The emerging terrifying man-made conflict-environment (social fabric with political instability and physical insecurity, disruption of social ties and networks with destruction of housing, transportation, communication, sanitation, water and food supply and health care system) thus created is a grave challenge to transcultural social and cultural mental health professionals worldwide. Children (the future citizens) are the most vulnerable group in conflict settings. It is reported that some 17 million children have been displaced by conflicts, more than 2 million children killed and over 6 millions have been seriously injured or permanently disabled since 1990. The total number of refugees and internally displaced people is estimated at 37 million worldwide. Among refugees, it is estimated that acute clinical depression and PTSD range between 40-70%. Conflict zone epidemiological studies on internally displaced persons from Thai-Cambodian border, Algeria, Ethiopia, Gaza and Uganda showed that 15-33% suffer from PTSD, rate of major depressive disorder reached to 71% in Uganda and psychopathology prevalence from these conflict zones has increased to 44% in comparison to non-traumatized population (17%). Mental health intervention at every steps (post-conflict recovery, consolidation of peace and reconciliation and sustainable development to safeguard health and social security of the affected population) is a new dimension for the cultural psychiatrist not only to address the new psychiatric issues of prevalence and pattern of immediate and long term mental health effects of armed conflicts and violence but also for protracted advocacy for peace and help creating an environment of non-violent culture and mind-set among communities to preserve the biodiversity. Our shared cultural values and identity is intimately linked with the specific biodiversity of the region.
Conclusion: The issue of Eco-Psychiatry is becoming more relevant to the mental health professionals in the contemporary world because of the changing environmental-culture due to pollution, climate change, deforestation, poverty, violence, lost social capital, emerging diseases and disasters, which have deep impact on human psyche, both in terms of resilience and coping failure. Recent research shows that social factors like stress, social support and coping process not only play a casual role in the development of psychopathology but also influence the complex interaction between genetic, biological, psychological and environmental risk factors. Preventive psychiatry and global mental health thus, will earn more mileage if it concentrate on the seeds of mental morbidity in the psychosocial context (environmental risk indicators) rather than only advocating ‘tablet’ prescribing.

References


How to work with narrative and metaphor: what anthropological understandings of 'culture' can contribute to transcultural psychiatry

Dr Kate Wood

As clinicians working in psychiatry, we are all anthropologists in our own way, even those who are more biologically than socially inclined: we are observers of human behaviour, interpreters of context, and explorers of narratives. In the spaces in which we practise, on ward rounds and in Emergency Departments, in clinics and in patients’ homes, we are constantly thinking of anthropological questions, whether we are conscious of this or not – questions which are fundamental to understanding the aetiology, phenomenology and context of our patients’ symptoms. Some of these questions are voiced to patients and their families; some are formulated within conversations with colleagues; and some remain at the back of our minds.

What is it, for example, about a 22 year old young man’s behaviours which signals to his family and community that something is deeply wrong? What cultural meanings might be attributed to the diagnosis of bipolar affective disorder in a 25 year old English woman? What might be the contextual factors, cultural and subcultural, that contribute to a 19 year old Somali patient active in a particular kind of ‘street’ inner-city peer culture chewing qat to excess? How do ethnicity and communication issues, as well as class and gender, impact on patients’ experiences of mental health services and on their patterns of engagement? What might be the meaning of persistent somatic symptoms such as ‘all over body pain’, dizziness or headaches in a 45 year old Bengali woman (in the absence of any organic cause)? At what point does a strongly valued religious belief in a 66 year old Pentecostal patient become a delusion?

We are all also anthropologists when we step back from the pressures of frontline psychiatry services and think more deeply about our patients, about mental disorder and the work we do. Why for example is there an epidemic of self-harming by cutting among teenagers? Why is the category of borderline personality disorder so apparently gendered? Are DSM5/ICD 10 diagnostic categories globally applicable? Both philosophically and practically, how do we work with ambivalence and with the multiple narrative versions of what has happened (or might happen) to our patient? What does mental illness do to someone’s sense of self and how is this connected to culturally constituted identities? How is mental disorder represented in popular culture including in mainstream films? How might subcultural music genres such as hip-hop be mobilised for anti-stigma campaigns? How is the increasing penetration of medical culture itself into daily life affecting people’s relationships with their minds and bodies, in relation for example to the medicalisation of ‘sadness’ and bereavement, and the apparent rise in hypochondriasis and the phenomenon of the googling ‘worried well’? How has psychiatry been used for political ends, notably to classify particular forms of behaviour deemed socially ‘deviant’ as ‘mad’ or ‘bad’ (Helman 2007)? How do migration and social deprivation increase the risk of mental disorder? How does delusional content - spirit possession, aliens, apocalypse, computer chips in brain, being in a TV reality show, and so on - vary across cultures and historical time periods?
Anthropologists think carefully about how language represents reality; clinicians too are embedded within layers of language and metaphor (our patient’s, our own, our institution’s, our medical sub-specialty’s and so on). To take an example (from Helman 2007), we work with lay models of stress – which in English is associated with metaphors relating variously to a heavy weight, a pressure cooker waiting to ‘explode’, wire (people are said to be ‘highly strung’, and prone to ‘snap’), fragmentation (people ‘crack up’ and ‘break down’), the malfunctioning of a machine (‘batteries need re-charging’), the depletion of a vital liquid (we say we are ‘drained’ and have ‘run out of steam’), and explosions (‘to blow one’s top’). What then might be the implications for communication when we work with patients whose first language we do not share and whose metaphors are opaque to us?

Medical anthropology focuses on the social and cultural dimensions of illness or ‘disease’, the body, healing and medical practice in different parts of the world. Psychiatric anthropology is an important branch of this which is practised both by anthropologists and transcultural psychiatrists who have trained in anthropology (there are various Masters courses now in the UK in Medical Anthropology and Global Mental Health). A classic popular image of the anthropologist is of the ethnographer or ‘participant-observer’, sitting with a notebook in the middle of the Papua New Guinean rainforest or observing Nuer initiation rites in Sudan, immersing themselves in local worlds in order literally to ‘learn’ the culture. While long-term immersive fieldwork remains a crucial ‘rite of passage’ in becoming a fully-fledged anthropologist, anthropological principles are increasingly used in a variety of applied medical and public health settings.

So what, broadly, is the relationship of culture to mental illness? As GP and anthropologist Cecil Helman (2007) describes in his classic textbook on medical anthropology, culture defines ‘normality’ and ‘abnormality’, delineates the difference between ‘abnormality’ and ‘mental illness’, influences the presentation of mental illness, and determines the ways in which mental illness is recognised, labelled, explained and treated by other members of that society including health professionals. ‘Culture-bound disorders’ – clusters of signs, symptoms and behavioural changes recognised by specific cultural groups – have been well documented by anthropologists both in developing country contexts and immigrant groups. However more recent anthropological critiques of the ‘culture-bound’ model (Helman 2007) argue that affluent Western societies have their own cultural ‘syndromes’: good candidates include anorexia nervosa, premenstrual syndrome, ‘parasuicide’ (particularly overdose), agoraphobia, exhibitionism, road rage, sex addiction, energy-loss syndromes like ‘burnout’, and ‘false memory syndrome’. To what extent do categories in DSM5 reflect these culturally situated concerns?

So how do we as clinicians engage with cultural considerations? Caution is required for if we are not careful, ‘cultural competence’ can become another ‘technical’ tick-box exercise for health professionals, a potentially crass tool bringing unexplored assumptions in its wake. ‘Culture’ is often seen as an attribute which people from ethnic minorities somehow possess more than those from majority social groups. As Arthur Kleinman, eminent Harvard professor of psychiatry and medical anthropologist (and founder of the international journal Culture, Medicine and Psychiatry) points out
in his critique (2006) of the ‘cultural competency’ model, we forget too easily about the culture of the professional caregiver—including both the cultural background of the doctor, nurse, or social worker, and the culture of biomedicine itself—especially as it is expressed in institutions such as hospitals, clinics, and medical schools. Culture is not static, and individuals often have complex relationships with different cultures, especially in this increasingly globalised world.

Kleinman & Benson (2006) makes the case for a revised cultural formulation in our clinical work, comprising the following elements:

- Ask about ethnic identity and determine its salience (or not) to the patient and their sense of self and place within family and social networks: As Kleinman (2006) writes: ‘The clinician can communicate a recognition that people live their ethnicity differently, that the experience of ethnicity is complicated but important, and that it bears significance in the health-care setting’.
- Ask what is at stake for patients and their families when they face an episode of mental illness: ‘This evaluation may include close relationships, material resources, religious commitments, and even life itself’.
- Reconstruct the illness narrative: ‘the patient and family’s explanatory models can then be used to open up a conversation on cultural meanings that may hold serious implications for care’.
- Consider psychosocial stresses and social support that characterise people's lives, and the range of interventions which may help.
- Examine the influence of culture on clinical relationships: as Kleinman & Benson (2006) write, clinicians are ‘grounded in the world of the patient, in their own personal network, and in the professional world of biomedicine and institutions.’ They point out that just as a crucial tool in anthropological fieldwork is the critical self-reflection that comes from the ‘unsettling but enlightening experience’ of being between social worlds so, too, it is important to train clinicians to unpack the formative effect that the culture of biomedicine and institutions has on the most routine clinical practices—including bias, inappropriate and excessive use of advanced technology interventions, and, of course, stereotyping’ (Kleinman & Benson 2006).

In conclusion, anthropological approaches have a great deal to contribute to psychiatric practice with their focus on socio-cultural context, narrative meaning and the primacy of the patient’s lived experience. I always remember the feeling I had the first time I sat with a floridly psychotic patient as a medical student, that I was an anthropologist once again, trying to establish some kind of rapport, elicit meaning from wildly metaphorical speech, and most of all get a sense of what the person I was sitting with was thinking and experiencing.

Dr Kate Wood is a Psychiatry Core Trainee in Bristol having had a ten year career as a medical anthropologist working in global HIV/AIDS prior to studying medicine. She is currently the South-West Representative on the TPSIG. Email: kate.wood4@nhs.net.
References


Cambodia & Mental Health

Dr L Jawad, MRCPsych
January 2015
Background

By the beginning of the 20th Century, Cambodia was under French rule. In 1952 King Sihanouk dismissed the government and took sole control of his homeland. And in 1953 Cambodia officially became independent from France. Sihanouk formed his own party which dominated the political scene between 1955 and the late sixties. This regime collapsed in 1968 after communists against the ‘Sihanouk Era’ began a civil war. Sihanouk left the country and following a vote by the National Assembly, his powers were dismissed. He was no longer the ‘chief of state’ and Cambodia was renamed the ‘Khmer Republic.’

America made attempts to stop the spread of communism by bombing Cambodia but the strength of the growing communist party proved indestructible. In 1975, the communists took over Phnom Penh. Cambodia would never be the same.

The leader of the Khmer Rouge, Pol Pot, expressed his desire to create the world’s first sole agrarian state in the quickest time possible and with no regard for the loss of human life. People in cities were forced to leave their homes and move to the countrysides. In just 48 hours Phnom Penh was empty. Cambodians were forced to work as farmers for long hours in dismal conditions. In the rare times they were fed, they were fed very little. Rice production became the main export of Cambodia and the sole purpose of each and every Cambodian’s existence. The regime adhered to extreme socialist values and removed all and everything that did not fit with this ethos. The educated were slaughtered: doctors, lawyers, teachers, and even those who wore glasses, simply because they 'looked intelligent', were shown no mercy. They were taken to prisons, tortured, starved and killed. Rules were sickeningly stringent. Anything which possessed the slightest degree of personal prosperity: private businesses, family relationships, religion, was banned. A multitude of irrational rules were set and those who did not comply were executed, often in their masses, at the killing fields.

It is not known just how many innocent lives fell victim to the Khmer Rouge regime, be it out of execution, starvation, or disease, but the figure is estimated to be around 2 to 3 million people.
Figure 1. Tuol Sleng Genocide Museum, a former school-turned-prison where over 12000 people were interrogated, tortured and killed.

Even though the Khmer Rouge Regime collapsed in 1979, years of fighting between Cambodians and the Vietnamese ensued denying Cambodia the peace she had dreamt of for so long. And despite having fled to neighbouring Thailand and no longer being in power, the Khmer Rouge’s presence still haunted the lives of many Cambodians. It was not until the end of the 20th Century that Cambodians could finally breathe a sigh of relief and proclaim that the war was over. Although politically stable, it is a country which is still suffering the ill effects of war. The ever present threat of land mines is a constant source of fear. In a country which underwent years of heavy shelling, it is believed that four to six million land mines remain undiscovered. How can they celebrate the end of war when so much of what it represents remains latent in their land? Indeed, the physical war may be over, but the emotional battle persists.

Figure 2. Cambodia, a nation scarred by land mines. 1 out of every 290 Cambodians have undergone a mine-related amputation¹
And it isn't just the physical effects of war which torment the lives of Cambodians. For an adult who, as a child, witnessed their parents being murdered in front of their very own eyes, the nightmare of repeatedly reliving their trauma shows no sign of remitting. The psychological repercussions are enormous. And whilst efforts were made to rebuild the physical healthcare system shortly after the collapse of the Khmer Rouge regime, mental health care would be ignored for many years to come.

**After-effects of the war**

With its long and harrowing past, it was inevitable that a significant proportion of the Cambodian population would be afflicted with a variety of mental illnesses, most commonly depression, anxiety and post-traumatic stress disorder. But in a country with so few resources in psychiatric care, it is not only difficult to quantify the prevalence of specific illnesses, but also to find ways of managing them. It is estimated that 35% of the country’s population suffers from some form of mental illness².

Cambodia opened its first psychiatric outpatient clinic, staffed by non-physicians, in 1994. At that time it had no psychiatrist. The country had two mental health specialists before the Khmer Rouge, both of whom were killed in the atrocities. Today, only 40 trained psychiatrists and 45 psychiatric nurses look after a population of 14 million people². At present, ten new psychiatrists are trained each year And just this, in a country where the suicide rate is 42 per 100,000 people- almost three times the world wide average³.

Of the 40 psychiatrists, only 10 reside outside of the capital, Phnom Penh, meaning many of those in rural communities who require help with mental illness cannot access it and receive very little community support². This has led to people being tied in chains or locked in cages because their relatives do not know how else to manage them². In addition to this blatant violation of human rights, many of these sufferers are excluded from society because of their illness².
There are multiple issues which hinder this much-needed speciality from flourishing: principally the labelling of psychiatrists as ‘mad doctors’ which dissuades people from entering the profession. However it is the ever present stigma of mental health that remains the biggest obstacle; whether it is the reluctance to seek help for mental illness for fear of being labelled ‘crazy’, or the more traditional belief that mental illness represents a curse which only a healer can reverse. Such traditional remedies may entail burning the patient’s skin so the ‘bad spirits’ leave the body. Many people don’t even understand what psychology is. There’s no question about it: mental health in Cambodia is very much in its primitive stages. The challenge lies not only in managing those who are mentally unwell, but in educating an entire population on the basics of mental health.

Whilst the government recognises that mental health is a priority, the funding it allocates specifically for mental health is a minuscule fraction, just 0.02% of its overall annual healthcare budget, in other words, as little as 2 cents (USD) per person.

Cambodia currently has two psychiatric inpatient units which house fourteen beds. Despite being admitted to a mental health unit, it is the responsibility of the patient’s family and friends to look after them. Patients are permitted to stay a maximum of two weeks after which point they are discharged back into the care of their families. In addition to these inpatient units, Cambodia hosts a number of outpatient services. On average across the country, between two and three hundred patients are seen in one morning, which means each doctor will review between thirty to forty patients per day. Put simply, Cambodia needs more psychiatrists.

The overwhelming demand for mental health care is why Cambodia has come to rely on foreign aid. A number of services have been set up over the last decade to help tackle mental illness. These range from private (Indigo) and public sector services (Khmer-Soviet Friendship Hospital) to NGOs (Cambodia TPO).
TPO

Set up as a branch of the Dutch NGO ‘TPO International’, the Transcultural Psychosocial Organisation of Cambodia was established in 1995. It is the country’s leading NGO in mental health. Their mission is as follows:

“to support those who are unable to care for themselves due to mental illness, poverty and lack of support by developing programmes that directly benefit people at the grassroots level, by improving their mental health and thereby increase their ability to care for themselves and their families”

Figure 3. The TPO Headquarters in Phnom Penh. (Right) Dr Sotheara Chhim, executive director of TPO Cambodia

Led by Senior Consultant Psychiatrist Dr Sotheara Chhim since 2000, TPO hopes to improve the mental health and quality of life of the Cambodian people through psychoeducation (to improve the public’s awareness of mental illness and to decrease stigmatisation), ongoing research programmes, training of mental health specialists (from psychiatrists, to social workers), and the provision of a multitude of multidisciplinary services (counsellors, self-help groups, therapists etc) in the community to aid the assessment and management of mentally unwell people. Furthermore, outreach services have been set up to teach local doctors who will then be able to provide mental health care (that is complementary to local health beliefs and traditional healing) to those individuals in rural
communities for whom accessing services would have otherwise been impossible. One challenge is educating patients on the importance of treatment compliance and follow-up. Significant drop out rates have been noted in patients who improve on drug treatment, returning to a normal level of functioning, but do not realise the need for longer term continuation of medication and follow-up.

The knowledge that improving mental health leads to benefits not only in a person’s physical health but also the economic prosperity of the entire country is what motivates its current mental health workers to continue striving in the face of adversity. With existing mental health services, the focus needs to be less on pharmacological management and more on a holistic method of managing psychosocial problems. Whilst the efforts of organisations such as TPO Cambodia are a step ahead in the way of progress there is still a long way to go. The challenges for Cambodia remain vast. But in a country where resilience is so palpable, nothing is impossible.
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Images: Figure 2. Photo of amputee courtesy of © Patrick Brown/Panos.
Figure 3. Both photos courtesy of TPO Cambodia.
Expression of Depression in Bengali Language and Culture

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Introduction: Modes of expressing or communicating distress is intimately related with personal and cultural experience of the individual (Nichter, 1981). Idiom of distress or style of expressing distress is dependent on the ethno-medical belief system of a particular community (Kirmayer & Young, 1998). This belief system is rooted in multiple systems of social meaning of distress or ill health, one important of which is the somatisation of psychological distress, particularly of affective disorders (Kirmayer and Groleau, 2001) and depression (Kirmayer, 2001). Linguistic expression of distress is crucially important not only for the clinical recognition and understanding of the problem, but also to plan the treatment and care plan. People usually express their subjective experiences in lay terminology (non-medical syntaxes) which is the representation of their perception, language, beliefs and social customs in the context of cultural values and attitudes (Westermeyer & Janca, 1997).

Culture influences the source of distress, the form of illness experience, symptomatology, the interpretation of symptoms, modes of coping with distress, help-seeking and the social response to distress and disability. It is difficult to have a universal concept of depressive disorders as cultural variations greatly influence the meaning and expression of dysphoric experiences, i.e., depression and anxiety which are English terms mostly reflecting emotional experiences of Western English speaking nations. In many middle-and-low income nations there is no equivalent term for depression, e.g. in Cambodia (Singh, 2015).
Bengali culture, language and expression of Depression: Bengali, also known as Bangla, belongs to the Eastern group of the Indo-Aryan branch of the Indo-European language family. Bengali is the most frequently spoken language in Bangladesh and second most spoken language in India (Thomson, 2015), with about 250 million native and about 300 million total speakers worldwide, it is the 7th most spoken language in the world by total number of native speakers and the 11th spoken language by total number of speakers (Asiatic Society of Bangladesh 2003). The national anthems of both India and Bangladesh were written in Bengali by Rabindra Nath Tagore, a renowned Bengali poet who got the Nobel Prize in literature in 1913.

Bengali or Bangla is a language native to the region of Bengal which comprises the present-day Indian states of West Bengal, Tripura, South Assam and neighbouring country of Bangladesh. Standard Bengali in Bangladesh and West Bengal has a wide variation in usage, accent and phonetics mostly specific to geographical locations. Rural-urban differences, socio-demographic and educational levels naturally influence language use and the expression of all emotions including depression. Psychological disorders affect people of every race and nationality. Depression is a psychological disorder that is widespread throughout the world. In India, depression is perceived and therefore expressed in a manner that is different from the way it is expressed in Western industrialised nations. There is not a word for depression in any of India’s languages (Mantle, 2003).

A person from India experiencing depression will express their complaints as being physical instead of emotional. These physical complaints are somatic symptoms of depression. People in India who have depression most often present with somatic symptoms initially. These individuals identify the most troubling aspects of their disorder to be aches and pains (Raguram, et al., 2000). The same is true for the Bengali people/patients. In Bengali parlance, the experience of depression is physical rather than psychological. However, one should not consider all Bengali people/patients as a single group who speak and share the same language. The way the upper middle class urban elite Bengali/patients would talk about their depression is different from the manner in which the rural Bengali people/patients express their feelings.
Many depressed Bengali people/patients do not report feeling sad, but rather express boredom, discomfort, crying spells, symptoms of pain, dizziness, and fatigue. Thus, in short the Western understanding and therefore the reporting of depression by patients is very distinct and different from their Bengali counterparts. Various patterns of somatisation are reported by the Bengali people/patients.

Physical complaints are often what prompt Bengali people/patient with depression to seek help. They will often reveal depressive symptoms after further probing by the health care professional. Through cultural awareness and sensitivity, the health care professional can make a correct diagnosis and develop a treatment strategy compatible with the patient’s needs (Raguram et al., 2000).

In many parts of the world, people avoid obtaining treatment for psychological disorders, including depression because of the stigma related with mental illness. This is true for an Indian and the Bengali people/patient where informing that someone is suffering from mental illness can have a negative consequence on that person’s/patient’s way of life. Social standing is cherished in Indian communities including among Bengali people. Some of the concerns are to do with the loss of status and respect in society as having depression is considered by many to be synonymous with diminution of esteem. An Indian person including a Bengali person/patient may be afraid to reveal emotional or psychological problems because they are afraid to cause pain or worry for the person they disclose their problems to, particularly their spouses or other family members (Weiss, et al., 2000).

Another concern that Indians including Bengali people/patients have about sharing their depression may have to do with marriage. In India most marriages continue to be arranged and this is also true of the Bengali community. People suffering from depression are concerned that if their psychological disorder became public, it could become difficult to arrange their marriage. Moreover, others are concerned that their illness may impact the arranged marriage of their close relative/s. Indian/Bengali men may be concerned that suffering from depression may reduce their capacity to provide for their family. The men may think they would not be considered suitable candidates for marriage or that, once married; they would not be able to
carry out their responsibilities within the marriage. Because of the stigma associated with psychological disorders like depression in their culture, Indian/Bengali people may find it easier to discuss the somatic symptoms of their disorder (Weiss et al, 2000).

**Linguistic expression:** *Mon* is the Bengali term for Mind. Following is a list of Bengali terms used to express clinical Depression:

A. Most commonly used terms by Bengali patients to describe depression include:

- *Manashik Awboshaad* (hopelessness)
- *Duschinta* (bad thoughts and worry)
- *Mon kharap* (feeling sad)
- *Mon Mora* (dead mind)
- *Mono Byatha* (pain in the mind)
- *Shorir durbol* (bodily weakness)
- *Manoshik chap* (mental pressure)
- *Ga jhim jhim* (uneasy sensation in the body)
- *Mone Ashanti* (joyless mind)

B. Urban educated Bengali speaking population usually express depressive state by stressing the psychological aspect of dysphoria. Some popular expressions are:

- *Bissannota* (mental sadness)
- *Monokoshto* (pain in mind)
- *Mono Bedona* (pain in mind)
- *Dukkho/ Bishad* (sadness)
- *Mon bejar* (bad mood)
- *Mon bhar* (heaviness of mind)
- *Shanti nei* (absence of peace)
- *Hatasha and Nirasha bodh* (feeling hopelessness and despair)
Jiboner kono mane neyi (no meaning of life/existence)

C. Very sensitive individuals, especially with advanced intellectual abilities, creativity or capacity for abstraction may express their depressed mood as ekakitta bodh (feeling of isolation or loneliness), klanti-bodh (feeling of tiredness and fatigue), moner tolpar/uthal pathal (mental turmoil), sunnyo bodh (feeling insignificant or zero)

D. Mostly in rural area where somatic expressions are predominant:

Shorir durbol (physical weakness)
Shorir bhari hoye aasha (physical heaviness)
Shara shorir jwala (generalised burning sensation)
Shara shorir byatha (generalised bodyache)
Buk bhaar (heaviness in the chest)
Buk dharfor (palpitation)
Mathay chaap (pressure on head)
Maatha ghora (vertigo)
Maatha jwala (burning sensation in head)
Mathay taap (head feels hot)
Mathay ‘gas’ (feeling of lightheadedness)
Matha bhar (heaviness in head)
Matha nostho/ pagol pagol laaga (feeling ‘going crazy’)
Brain ‘short’ (derangement inside the brain)

It is also of clinical interest that Bengali female depressed patients express sad mood more in terms of somatic (sorir or body) distress (So, 2008) where as males identified with more psychological or mental (mon or mind) expression. Research (Verdenburg et al., 1986) showed the importance of gender difference in expression of depression from other cultures also.
Conclusion: Globally depression is a major public health problem (Greenberg et al, 1993) and about 6% of the population meet the criteria for major depressive disorder/dysthymia at any time (Keller et al, 1992). By 2020 it will be regarded as the second highest disease burden (Shafi & Shafi, 2014). Thus, proper identification and treatment plan from a cross-national perspective is a vital task in the global fight against depression (Scot & Dicky, 2003). Linguistic barrier and presentation of depression (Ahmed & Bhugra, 2007) thus is an important research agenda in different non-western cultures like China and Japan (Rider et al, 2008; Targum et al, 2013). The present paper highlighted the linguistic expression of depression in Bengali language and culture and may be a clinical aid to those health professionals dealing with patients from Bengali ethnicity.

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Interview with Professor Laurence Kirmayer: Director of Cultural Psychiatry, McGill University, Montreal, Canada.

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I remember having a stimulating conversation with a good friend of mine, a professor of political economy who is also a consultant for the United Nations on violent radicalisation. After having travelled all over the world in his quest to fathom the political and economic determinants of extreme behaviour, he concluded that ‘most of these people were just in the wrong place at the wrong time...’ All of us have been, no doubt, the victim of circumstance in one way or another (albeit the consequences perhaps are not so grave for some as they are for others). One could equally, however, argue that being in the right place at the right time would qualify as a good working definition of luck (‘luck is when preparation meets opportunity’ is a quote that I chanced upon and one that resonates with me). And so here I am, braving the elements in Montreal, Canada (it is -30 degrees centigrade over here and the streets are laden with snow which reaches as high as my knees in certain areas) after having met Professor Kirmayer fortuitously in a World Psychiatry Association event in the heartland of the world, the Holy Land itself. Professor Kirmayer cordially and graciously extended an invitation to present in Canada, an invitation I just couldn’t refuse. I cannot help but feel how very fortunate I am to be in his presence (Professor Kirmayer exudes serenity) and to have this opportunity to interview a world authority on cultural psychiatry. Indeed, McGill University is
Ahmed Hankir (AH): Thank you for accepting my invitation to interview you. My first question is this, ‘Who is Laurence Kirmayer?’

Laurence Kirmayer (LK): Well, professionally, I am James McGill Professor and Director of the Division of Social and Transcultural Psychiatry at McGill University. My work straddles both academic and clinical areas of psychiatry as I am also a staff psychiatrist at the Department of Psychiatry of the Jewish General Hospital, and a Senior Investigator at the Lady Davis Institute for Medical Research, Montreal, Canada.

AH: Could you signpost your trajectory hitherto?

LK: My educational and training background was originally in physics and mathematics and then psychology as an undergraduate at McGill University. During my undergraduate years, I began in physiological psychology but became increasingly interested in cognitive and social psychology. In my final year of medical school, also at McGill, I had the good fortune to take a seminar in ethnopsychiatry (which was essentially on work at the intersection of anthropology and psychiatry) with the medical anthropologist, Margaret Lock. This opened up a vista that was extremely exciting. After medical school, I completed my residency in psychiatry at the University of California Davis in Sacramento, California. I was fortunate enough to meet Byron and Mary-Jo Good who were also central in a renewed engagement between medical anthropology and psychiatry initiated by the work of psychiatrist/anthropologist Arthur Kleinman. In Sacramento, we started a reading group in culture, personality and psychopathology. This gave me a chance to explore the relevance of psychological anthropology to clinical questions during my training. We also had a chance to take part in a consultation program that worked collaboratively with local healers from different traditions.

After three years in Sacramento, I returned to Montreal or a research fellowship in 1981, and that is when I became aware that McGill had a long and illustrious tradition in what was then called transcultural psychiatry. I began working as a consultant in consultation-liaison psychiatry with medical patients at the Jewish General Hospital (one of the teaching hospitals affiliated with McGill) and it was clear in that work that cultural background has a powerful impact on everyone’s experience of illness, and not only on psychiatric illness.

AH: What was the focus of your research activities?
LK: Initially, I focused on the problem of somatization, because it was clear that in general hospital and primary care settings much of mental illness is manifested mainly as physical symptoms i.e. ache, fatigue and other ‘medically unexplained symptoms’ (MUS)). My interest was in understanding how culture shaped the expression of distress and the impact this had on the recognition and treatment of common mental disorders in primary care. My clinical work in consultation-liaison and emergency psychiatry underscore the importance of physical symptoms of emotional distress across diverse cultural groups.

Over the years, I have continued to study somatization and other modes of expressing distress to understand how people think about illness and communicate their distress to others. The key questions that I wanted to answer were, ‘What kinds of knowledge do people have about illness?’ and ‘How do their perspectives interact with healthcare systems and the other social contexts they must navigate?’

AH: Was there an experience in particular that was the most memorable in influencing your research?

LK: I had many personal and clinical experiences that convinced me of the importance of understanding the patients’ point of view. One that comes to mind was an experience of my own “attributional style.” One day, I was on the floor playing with my infant daughter, and I vividly recall feeling so tired that I found it hard to get up from the floor. At the time, I interpreted this fatigue as a sign of depression - though my mood was fine. I saw my family doctor who diagnosed me with asthma (which I had never had before). So it seems I was engaged in psychologising, rather than somatising! Because I am a psychologically oriented practitioner, it was easy for me to devise a psychological explanation for my experience of fatigue. This really drove home the point that the ways we explain symptoms depend on personality, past experience and social context. It is important, however, to say that the division between psychological symptoms and physical symptoms can be quite arbitrary. Illness affects us as whole organisms - involving our bodies, thoughts and feelings. What we focus on - and what we feel we should conceal - is influenced by culture. Indeed, the cultural shaping of illness experience is relevant to doctors across all specialties. My own clinical work in liaison psychiatry focussed on aspects of psychiatry, psychology and social sciences that are very applicable to general medical care. The psychosocial aspects of care are often recognized in dealing with common conditions like Fibromyalgia Syndrome in rheumatology or Irritable Bowel Syndrome in gastroenterology. But understanding the personal and social context of illness is essential not only for categories of medically unexplained symptoms or functional...
syndromes which are a large part of practice in every medical specialty but for every health problem. We human beings are, after all, cultural beings. The way that we learn to see the world shapes every aspect of experience, including the ways we perceive and cope with illness and disease.

AH: What is the distinction between ‘social’ and ‘culture’?

LK: Although there have been debates in the social sciences and psychiatry about the distinction and their relative importance, the constructs of the social and the cultural cannot be sharply distinguished - they are intimately intertwined. People who want to emphasise the importance of economics and power tend to fall into the social camp; those who focus on the role of values, knowledge and discourse, would fall into the cultural camp. But it is important to appreciate how the two are inter-dependent. Who you are - the social position you occupy and the structural forces you experience - changes if you go to a different cultural environment. Cultural values are used to justify and maintain social structural arrangements including the inequalities that make people vulnerable or sick. Even the scientific basis of medicine has a cultural element. Although we try to refine our medical practice through scientific empiricism, at any given time it is shaped by cultural ideas and practices.

AH: What is the difference between ‘Eastern’ and ‘Western’ psychiatry?

LK: The distinction between “East” and “West” is always a bit of a caricature. In fact, it usually involves people of “the West” (i.e. Europe and North America) projecting their notions onto “the East” (most of the world!) in a way that results in a kind of mirror image. The notion of the person in the West tends to be very individualistic, while in many other cultures people tend to think of themselves in more communal, familial or collectivistic terms. For example, the normal path of development in the West is for young people to become autonomous, to leave their families and set up a new household. However, in much of the world, people live their whole lives in the orbit of extended family. This is not a lack of development but a different path governed by different norms and values. Cultural psychiatry is interested in looking at these developmental trajectories more critically and more open-mindedly. Take for instance the fact that in psychiatric nosology (DSM-IV) there is a dependent personality disorder but no independent personality disorder. If you juxtapose different ways of life, we learn a lot about normal development and pathology from cultural variation. This cultural diversity is important to appreciate, not only in the context of a globalising world, but equally from a basic science point of view. Understanding culture would guide us not only
to more appropriate care for the patients we see, but also toward more accurate theories of neurodevelopment in health and illness. There is an emerging field of cultural neuroscience examining this variation. I find this extremely interesting because, like many who are attracted to psychiatry, I am looking for ways to integrate all the different levels and facets of human experience. In psychiatry, there has long been an emphasis on the biopsychosocial approach, which points toward a truly holistic and person-centred approach to medicine.

AH: What is the current state of play of cultural psychiatry?

LK: Cultural psychiatry has focused on health disparities - both globally and locally, in terms of the needs of immigrants, refugees and ethnocultural minorities. At the same time, it has continued to advocate for an integrative approach to care that challenges mainstream psychiatry. In recent decades, there has been a striking biologisation of psychiatry, especially in the U.S., with the assumption that neuroscience is going to give us the core understanding of the aetiology and treatment of illness and disease. To a large extent that has become the dominant view and the perspectives of social science and psychology have been downplayed. But I would argue that human biology is cultural biology. The brain is the organ of culture - and we use our brains to acquire and adapt through cultural inventions like reading, mathematics and other complex social practices. Many of the problems we see in psychiatry may reflect not structural abnormalities in the brain but the consequences of learning (programming the brain) and the unhealthy environments and social relationships people must negotiate.

AH: What are some of the advances we can look for from cultural psychiatry?

LK: A major step in recent years has been the effort to clarify how to collect and organize information about culture and context in mental health. DSM-5 (the recent revision of the diagnostic system of the American Psychiatric Association) introduces a Cultural Formulation Interview. This is a basic approach to exploring the social and cultural context and meaning of illness. It should be part of the toolkit of every physician.

When I was a medical student one of the challenges in medicine was learning how to address sexuality. Some effort went into teaching us how to take a sexual history and becoming comfortable addressing issue of sexual dysfunction, sexual orientation and related aspects of identity and experience. Nowadays, I think one of the areas that has become especially challenging is addressing religion and spirituality. This is largely because of the geopolitical situation that has saturated us with images and stereotypes of “the Other” usually depicted as someone of very different religious or
cultural background. Just as with addressing sexuality, a lot depends on our ability to develop a
certain maturity, openness and ability to empathize with others to understand and address their
concerns.

Cultural psychiatry also has the potential to help us rethink the notion of health and healing in
medical care. In the 1970s, Miriam Siegler and Humphrey Osmond (the person who coined the word
psychedelic) wrote a book about Aesculapian authority, the kind of authority that doctors or healers
are given in society. In addition to the technical aspects of biomedicine based in biology, we need to
understand where our social authority and psychological influence comes from. Although we seek to
ground our practice in scientific evidence, in most cultures, healers draw their power and authority
from some connection to religion or spirituality. Perhaps the most elementary system of medicine is
shamanism. For the shaman there was no medical schools, no diploma to warrant his expertise.
Instead, the shaman's authority stems from his or her own experience of illness—what Jung called
the archetype of the “wounded-healer”. There is some basic emotional logic behind this notion of
authority. This is why we have self-help groups and this primordial level still lies underneath all of
what we do in biomedicine. So, as a physician, coming to terms with one’s own vulnerability, and
using it to help understand the predicaments of our patients can provide an important path to
empathy and a way to mobilize their own capacities to heal. All medical intervention has
psychological and social dimensions that contribute to the effectiveness of healing. The healer has to
be open to the healer in the patient. It is not the healer who has the absolute power. We need to
courage the patient to be active rather than passive. This view of the cultural and psychological
dynamics of healing gives us another way to look at our medical institutions and ways of practice. It
encourages us treat patients with great respect and appreciate many of the indignities they endure.
Hopefully, it will lead us to re-examine our larger culture. By thinking through the conditions for
psychological healing and wellness, physicians can contribute to making our medical institutions
more hospitable and effective. The recognition of cultural diversity in health care is one key
dimension of this hospitality and duty to care. It is also a way to contribute to building pluralistic
societies that are inclusive. But this will require changes in our own attitudes toward others, to move
beyond stereotypes, and understand others on their own terms. In fact, we must be advocates and
agents of cultural change in the broader society, if we want things to get better for our patients.

AH: Professor Kirmayer, thank you once again for accepting my invitation to interview you.
This symposium was held at the Royal College of Psychiatrists in London on the 8th November 2013.

Eight Speakers participated in this event. It was well attended and generated food for thoughts and stimulated audience for future similar activities.

We present short biographies of the speakers and summaries of their talks to spread the information to people who didn’t manage to attend.

Professor Julian Leff - The Royal College of Psychiatrists - has kindly agreed to Chair our symposium.

The Transcultural Psychiatry are delighted and honoured that Professor Julian Leff has agreed to Chair our symposium and also agreed to give a brief talk on:

**Traditional Healers, a Liability or an Asset?**

**Professor Julian Leff**

Qualified in medicine at University College Hospital. Trained in psychiatry at the Maudsley Hospital. After qualifying joined the MRC Social Psychiatry Unit, Director John Wing. Worked on the WHO International Pilot Study of Schizophrenia and the subsequent Determinants of Outcome study with Norman Sartorius and Asen Jablensky. These experiences stimulated a strong interest in transcultural psychiatry. Completed an MD on the first UK randomised controlled trial of oral antipsychotic medication for prevention of relapse in schizophrenia. Began research on Expressed Emotion in family carers with Christine Vaughn, This led to a series of randomized**
controlled trials on family interventions for schizophrenia. Was appointed Director of the Social Psychiatry Unit on Wing’s retirement. Conducted a series of studies over 13 years on deinstitutionalization, which informed government policy. Carried out a randomised controlled trial of couple therapy versus antidepressants for depression. Elected Honorary Member of the Institute of Family Therapy and the International Society for the Psychotherapy of Schizophrenia. First recipient of the Burgholzli Prize of the University of Zurich. Investigated the causes of the epidemic of schizophrenia in UK African-Caribbean’s. Followed this by participating in the AESOP study as a principal investigator. Since retiring in 2002 have developed Avatar Therapy for people with persistent auditory hallucinations, and am currently evaluating this in a randomised controlled trial.

TEACHING ACTIVITIES: Workshops in Family work for schizophrenia internationally and in the UK. Teaching family work in South Africa on a yearly basis.


SPEAKERS:

1. Is Psychopharmacology Important in Practicing Transcultural Psychiatry in Africa?

Dr. David C. Henderson is an Associate Professor of Psychiatry at Harvard Medical School and an Associate Psychiatrist at Massachusetts General Hospital (MGH). He serves as Director of The Chester M. Pierce, MD Division of Global Psychiatry at MGH and Director of the MGH Schizophrenia Clinical & Research Program.

Dr. Henderson’s main research interests are psychopharmacological and antipsychotic agents in the treatment of schizophrenia, impacts of antipsychotic agents on metabolic anomalies and glucose metabolism, and ethnic and cultural
psychiatry. Dr. Henderson also studies trauma in areas of mass violence and develops programs to assist vulnerable populations. In addition, he provides technical assistance to governments and organizations on mental health policy and planning – most recently, for the Republic of Liberia in collaboration with the Ministry of Health – and builds global partnerships that increase local clinical, research and training capacity in resource-limited settings. He has worked in international and conflict-affected areas for the past 18 years in places such as Bosnia, Cambodia, East Timor, Ethiopia.

2. From London to Zimbabwe and back: A trainee’s perspective.

Dr Angharad Piette

Dr Angharad Piette is a Higher Trainee in psychiatry in London. She did her medical degree at Cardiff University and worked in South Wales before coming to London to do Core Psychiatry Training on the UCLP scheme. She took a year out of training and spent 6 months in Zimbabwe working as a clinical tutor before starting her current post as an ST4 at the Maudsley Hospital on the South London and the Maudsley rotation.

Title: 'From London to Zimbabwe and back: a Trainee's perspective.'

Angharad Piette spent six months in Zimbabwe as a clinical tutor, working as a psychiatrist on the wards and outpatient clinics at the country’s teaching hospital in Harare. She also joined the Department of Psychiatry at the University of Zimbabwe and introduced a new module for undergraduates on depression. Along with Zimbabwean colleagues, she also introduced simulation teaching and OSCEs to the undergraduate curriculum. This post formed part of the Medical Education Partnerships Initiative (MEPI), which links African medical schools with those in high-income countries.

Zimbabwe has been through a period of economic and political instability which has impacted on mental health service provision and education. The US dollar was introduced as official currency in 2009 and since then the country has seen a period of increased stability and has started to recover economically. The working
environment for psychiatrists remains challenging but there is optimism and enthusiasm for improvement.

In this talk, she will discuss the highs and lows of her experience of working in Zimbabwe. She will also discuss the differences and similarities between psychiatry in Zimbabwe and in the UK.


Dr Viviane Ngwombo

Dr Viviane Nzouonta Ngwombo graduated as a Medical Doctor from the Medical School of Lome, Togo in 2005. She then moved to join her family in the UK where she successfully completed all the examination and professional requirements to get full registration with the UK General Medical Council.

After working in a variety of positions at St Georges Hospital in London, Frenchay Hospital in Bristol and the Royal United Hospital in Bath, she has been a Speciality Trainee in psychiatry with the Severn Deanery since August 2011. As part of this training, she has been involved in General Adult Psychiatry Inpatient and Community, Child and Adolescent Psychiatry, Old Age Psychiatry and Early Intervention and Recovery Service with hospitals in Devizes, Wiltshire and Bath.

She is currently working with Early Intervention /Recovery Team in Bath as a Year 3 Core Trainee.

She is currently developing a special interest in cultural psychiatry, in particular the cultural use and misuse of substances and its psychotic effect among the UK ethnic minority group in Bristol.

She is co-author of a paper on the influence of the rate of haemoglobin F on scalable profile homozygous sickle cell anaemia, in which her MD research thesis results were presented.
Summary
Cameroon is twice the size of UK and 1/3 of its population. Outside major cities, hospitals are poorly equipped. A significant portion of the population still believes in traditional healers.

Hospital
On arrival, patients pay the consultation and medical record fees ~£ 4. There are 32 inpatient beds, with an average of 4 beds per room. Patients must have relatives with them 24hr/7. Hospital does not provide food or toiletries. Patients just walk-in; they often travel long distances before reaching the hospital. Patients expect to be seen by a doctor on the same day and leave with a prescription. Cameroon has 7 practicing psychiatrists. 5 others are in-training and few more are abroad. Over the past years, there has been a reduction in the number of people wandering the street. The government has launched a campaign to train and recruit mental health professionals. Campaigns of sensitisation are organised to raise public awareness on the condition. They aim to break the stigma associated with mental illness in the country.

Management:
1-FGA’s are more affordable. For those who can afford it, SGA are prescribed.
2-Vitamin B complex and EEG are a Must.
3-Tiapride, instead of anti-cholinergic drug for EPSE
4- Major depression: slow IV Clomipramine for 4 days followed by oral SSRI.

Medications requiring regular monitoring are not used.

4. What does Western psychiatry have to offer to African countries?

Dr Derek Summerfield
Dr Derek Summerfield is an NHS Consultant Psychiatrist, HIV Mental Health, South London & Maud NHS Trust; Hon Senior Lecturer, Institute of Psychiatry, King’s College; formerly Research & Teaching Associate, Refugee Studies Centre, University of Oxford; Hon Fellow, Egyptian Psychiatric Association.

I will review what Western psychiatry, its research and clinical approaches, have to offer a continent with a multitude of differing mentalities, definitions of a person, and traditions of help-seeking, and where the vast majority of its inhabitants are stalked by poverty and lack of rights. I will discuss the overarching issue of validity in psychiatric methodology and its implication for psychiatry’s truth claims. I will discuss the naiveté and self-righteousness of Western scholarship, evident in the assumption that Western knowledge in this arena is universally applicable whereas local knowledge is merely that, local. DSM and ICD are documents attesting to medical imperialism. But in discussing whether we have anything to offer, I will distinguish between functional psychiatric states and organic ones.

5. Transcultural Perspective of Research and Psychiatric Practice in Accra Hospital.

Dr Olimpia Belea

Dr Olimpia Pop is a Romanian born psychiatrist. She graduated from the ‘Carol Davila’ University of Medicine and Pharmacy, Bucharest in 1998. She worked as a GP trainee and then as a psychiatry trainee in Romania, before continuing psychiatric training in the UK in 2004. She completed her dual training in general adult and addiction psychiatry in 2011. Since then she has been working as a locum consultant in addiction psychiatry at South West London and St George’s NHS trust. Her special interests include the interface between Christian Orthodox faith and psychiatry, international psychiatry and sleep disorder in people with addiction.

Three –month volunteer programme in Ghana

The talk will focus on my three- month volunteer programme at the Accra Psychiatric hospital in Ghana in 2008, whilst a ST4 in psychiatry at South West London and St
George’s NHS trust. The aims of my assignment were to teach psychiatry to the medical assistants and to develop the inpatient service. I also want to present some of the findings from my research with Dr Akwasi Osei, Chief Psychiatrist of Ghana and others called ‘The multiple roles of the psychiatric hospital in a developing country: the case of Accra Psychiatric Unit’. Overcrowding in Accra Psychiatric Hospital is compounded by lengthy hospital stays. We found that some patients were not leaving the hospital despite being discharged, while others were not being discharged despite improvement in mental state.

6. **Transcultural Experience of an International Volunteer in Africa.**

Dr Peter Hughes

Dr Peter Hughes is a graduate from UCD Dublin. He is currently a General Adult Psychiatrist in St. George's London. He has worked in Australia, Ireland, Haiti, Chad as well as assignments in many other countries. His main overseas interest is in the WHO MH GAP implementation Guide and integration of mental health in primary care in low resource settings including conflict and disaster zones. He is a fellow of the Royal College of psychiatrists, member of International advisory Committee of college and founder of Volunteering Special Interest Group of College.

Dr. Hughes is talking about Psychiatry in Africa specifically and socio-cultural aspects of establishing a programme of integrated mental health into primary care partnering with WHO and Sudan Ministry of Health.
7. Update of transcultural psychiatry SIG

Dr Hellme Najim

Graduated from Mosul Medical College 1977.
Membership of the Royal College of Psychiatrists 1983.
Assistant Professor of Neuropsychiatry Mosul University Iraq 1989 - 93.
Assistant Professor in Neuropsychiatry Sana'a University Yemen 1993 - 94
Lecturer at The Institute of Psychiatry London 1996-8
Consultant Psychiatrist South Essex University Foundation Trust 1998 - present

Special interest:-
Psychopharmacology, Service provision of people with severe mental illness,
Interface between primary and secondary care.
He was elected as a chair for the Transcultural Psychiatry Special Interest Group at the Royal College of Psychiatry in July 2012.

Transcultural psychiatry deals with psychiatric disorders and services in different cultures and how cultural systems and beliefs influence psychiatric presentations and response to treatment.

The revolution in transport and communication has led to more interaction and mobilization of people across the countries and continents. The global village concept has developed which made people more aware of different nations and customs much more than before.

Conflicts and unrest has displaced people from their countries. They settled in their hosting countries and exposed them to different cultures and enriched the hosting cultures with their traditions. Economic immigration has made people move from their home countries searching for a better life. Usually people move from low income to high income countries.

Immigration has been proved to be stressful and immigrants have high psychiatric morbidity internationally.
Psychiatrists practicing in hosting countries started to encounter presentations they haven’t studied or come across before. Transcultural Psychiatry jumped from the shelves of libraries to day to day practice, especially in the West where waves of immigration have rippled on their streets.

The Royal College of Psychiatrists, as an academic institution, has always paved the way for psychiatric training, research practice in the United Kingdom and worldwide.

Transcultural Psychiatry special interest group is the relevant venue to lead the way in this field.

In order to achieve this objective, our plan is to organise regular meetings and symposia about psychiatry in different parts and to publish our electronic newsletter regularly. We will create an electronic forum to discuss transcultural issues and update news worldwide. We will try to liaise with other special interest groups at the Royal College and create channels of communications with ethnic minorities in the United Kingdom. We will also liaise with self-help groups and different cultural organisations, through attending their activities or inviting them to our activities.

All these objectives cannot be achieved without your help and support.

It was organised by Dr. Mark Agius and Dr. Rasheed Zaman. They have been organising this conference over the past few years periodically.

It is held every two years. It involves a lot activities and countries. It exposes psychiatric practice in different parts of the world and make psychiatrists exchange their experiences and meet each other in a friendly, relaxed atmosphere.

About 45 countries were represented and different concepts and themes were discussed. They outlined psychiatry as an interesting medical speciality which highlights culture and its influence on the formulation and management of psychiatric disorders.

Transcultural Psychiatry SIG had its representation through Dr. Mark Agius who is the SIG representative for the Mediterranean. A talk was delivered by the chair about transcultural influence in Psychiatry.

The delegates parted on the promise to meet again in Sep 2017.
Transcultural psychiatry The Scope and the Future.

A talk which was delivered by Dr. Hellme Najim at North Essex Community Care NHS Trust in May 2015.

It indicated that Transcultural psychiatry is a relative new branch in psychiatry which was established in MaGell University in Canada and has sprawled all over the world.

It has liberated itself from the unidimentinal western point of view and has evolved to be more comprehensive and inclusive.

It has become more relevant due to the advances in transport and communication which made people chose to move towards more resourceful places. People might have been force to move due to different conflicts and difficulties.

It concluded by emphasising increasing importance of transcultural knowledge in practicing psychiatry all over the world in general and in the western world in particular. It invited different colleagues to contribute and attend Transcultural Psychiatry Activities.