Transcultural psychiatry

Special interest group

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Transcultural Psychiatry

Special Interest Group (TSIG)



NEWSLETTER

Autumn 2026

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MESSAGE FROM THE CHAIR

Dear Members,

It is a great pleasure to welcome you to the Autumn 2026 edition of the Transcultural Psychiatry Special Interest Group (TSIG) newsletter.

I am delighted by the exceptional contributions to this edition, which reflect the breadth of expertise, enthusiasm and commitment across our growing TSIG community. My sincere thanks to everyone who has helped make this another engaging and thought-provoking issue.

The past few months have been particularly exciting and productive for TSIG, marked by several memorable milestones. A special highlight was TSIG making history as the first Special Interest Group within the Royal College of Psychiatrists to participate in the Mind Masters Quiz at the RCPsych International Congress in June 2026. It was a proud moment to see TSIG represented alongside the College's Faculties, Divisions and other SIGs, with our members enthusiastically cheering us on.

Another important milestone was our inaugural TSIG drop-in session on 28 October. The enthusiastic participation, thoughtful exchanges and inspiring discussions generated a wealth of ideas on education, mentorship, collaboration and practical resources to advance culturally informed psychiatric care. Building on this encouraging start, we plan to hold these sessions quarterly, providing an informal, welcoming space for members to connect, exchange perspectives and help shape TSIG's future direction.

This year also marks the centenary of the College's Royal Charter, an occasion that invites us to celebrate its distinguished history and look ahead to its future. Attending the unveiling of the Centenary Appeal Donor Wall on 5 November was particularly meaningful for me. It offered an opportunity to reflect on the College's remarkable legacy and the invaluable opportunities it has created for generations of psychiatrists. I encourage members to explore the Centenary Appeal (rcpsych.ac.uk/centenary-appeal) on the College website and consider supporting its future aspirations.

Looking ahead, I am especially excited about our inaugural TSIG International Online Conference on 27 November 2026. Bringing together distinguished national and international speakers, trainees, SAS doctors and colleagues from across the profession, this landmark event promises stimulating discussions, valuable insights and opportunities to strengthen professional connections and collaboration. I warmly encourage you to register, participate and share the event widely across your networks.

As TSIG continues to flourish, our community's strength lies in the diversity of its voices and the active involvement of its members. Whether by contributing to the newsletter, participating in events, sharing research, mentoring colleagues or proposing new initiatives, every contribution helps us move forward. I particularly encourage trainees and early-career psychiatrists to get involved, share their ideas and help shape TSIG's next chapter. Your perspectives, creativity and energy are vital to our future.

I express my heartfelt gratitude to our Executive Committee, newsletter contributors, members and College colleagues for their continued dedication, enthusiasm and invaluable support. Your collective efforts are instrumental in making TSIG a vibrant, inclusive and forward-looking community.

I hope you enjoy this edition and find fresh perspectives, inspiration and opportunities to connect and contribute. Together, let us continue to build bridges across cultures, celebrate diversity and champion culturally responsive care as an integral part of psychiatric practice.



As the year draws to a close, I would also like to extend my warmest seasonal greetings to you and your loved ones. Wishing you a peaceful and joyful festive season, a restful end to the year and a happy, healthy and fulfilling New Year. I look forward to another inspiring year of learning, collaboration and shared achievements with our TSIG community.

With warmest wishes,

Dr Saima Niaz
Chair
Transcultural Psychiatry Special Interest Group
Royal College of Psychiatrists

NOTES FROM THE EDITOR

It has been a very busy and productive period for the Transcultural Psychiatry special interest group (TSIG), and I am delighted to welcome you to this Autumn 2026 edition.

Our Chair, Dr Saima Niaz, opens this edition with a message on recent TSIG milestones and the months ahead.

Like with past editions, I want to draw your attention to the interesting articles in our section Culture, thoughts and words. Dr Eslam Elmasry invites us to notice the "elephant outside the room": differences of race and culture overlooked in the therapy room. Dr Ayesha Sumina writes about her experience as an international medical graduate, mentoring colleagues and challenging stigma around mental health. Dr Mala Singh shares her journey into transcultural psychiatry across India, Iraq, Nepal and the United Kingdom. Dr Nadia Liaqat reflects on migration, identity and belonging after moving from Pakistan to the UK. Please don't miss Dr Ananta Dave's poem, *Love, Unmoored*, on belonging and the love that leadership calls for. Professor Rajashree Ray-Bandyopadhyay reflects on working between India and the UK, and on listening, identity and spirituality. Dr Saman Khan writes about the UAE term "People of Determination" and how words shape attitudes to disability. Gloria Akinpelu, a fifth-year medical student, describes founding Black Grls In Psych to support Black women interested in psychiatry. Dr Samila Asad reflects on midlife and how culture shapes what is said in the consulting room. Dr Michael Akeju, in *Whose Childhood Counts?*, asks how cultural ideas of childhood influence adult ADHD assessments. Dr Sana Fatima reflects on migration, identity and the borders we draw. Dr Larry Culliford looks back on a transcultural life. Dr Astha Sharma, in *Kunst and Psyche*, explores creativity, spirituality and the birth of "Psychartica". Roopam Kumari shares her Madhubani painting and reflects on this Mithila folk art as a source of calm and connection. Finally, Dr Nkechinyere Eze and Dr Geraldine Odo write about cultural dance, community and resilience among young people.

In Other events, you can read Dr Fabida Aria's lovely account of the second Celebrating Cultures Fundraiser, held in October in Birmingham, and Dr Anis Ahmed's reflections on the British Bangladeshi Psychiatrists Association Annual Conference 2026 in London. You will also find news of DiGo Talks, an international learning community founded by Dr Divyam Goswami, bringing together colleagues from 17 countries, and of Dr Qutub Jamali's new book, *First Steps on the Publication Ladder*.

In Past TSIG activities, you can read about our first TSIG drop-in session on 28 October, led by our Chair Dr Saima Niaz, previous Chair Dr Fabida Aria, and me.

Looking ahead, our TSIG Autumn Conference, *Beyond Borders*, will take place online on 27 November 2026, with a keynote by Professor Dinesh Bhugra. We also look forward to the RCPsych International Congress in Glasgow, from 14 to 17 June 2027. I hope to see many of you at both.

I hope you find these pieces interesting and inspiring, as we would love to hear from you, your experiences and your ideas. If you would like to contribute to a future issue, we kindly remind colleagues that submissions should focus on transcultural psychiatry and the cultural aspects of mental health. Whether you want to contribute with an article, let us know about an event which you attended which made you reflect on transcultural psychiatry, or you want to join our exciting TSIG committee, you will be more than welcome. The message is clear: everyone's culture matters, so let's make sure our psychiatric practice reflects that.

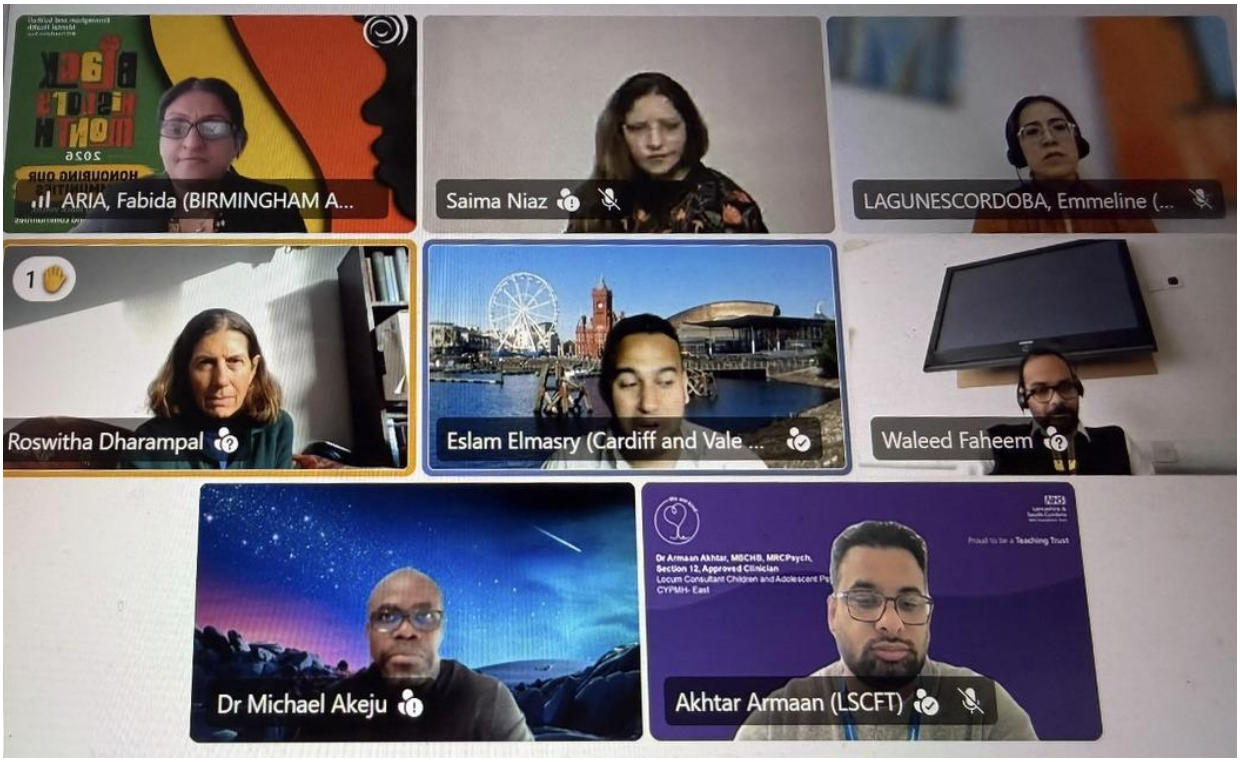
Dr Emmeline Lagunes-Cordoba



PAST TSIG ACTIVITIES

TSIG Webinar

On October 28th, we hosted our first TSIG drop-in session, led by our current chair Dr Saima Niaz, our previous chair Dr Fabida Aria, and newsletter editor Dr Emmeline Lagunes-Cordoba. This session aimed to increase the TSIG visibility and improve engagement with those interested in transcultural psychiatry, offering a space where people can share ideas, and contribute to our TSIG community. We were glad to welcome psychiatrists from different backgrounds who shared ideas and projects they have worked on focused on the importance of improving cultural awareness and the impact of culture on people's mental health.



TSIG drop-in session, 28 October 2026

We are hoping to run these drop-in sessions four times a year, with the next session due to be confirmed soon, so, keep an eye on incoming TSIG emails, so you can join us next time.

OTHER EVENTS

Celebrating Diversity, Culture and Community



In October 2026, Birmingham and Solihull Mental Health NHS Foundation Trust held its second Celebrating Cultures Fundraiser. All guests were welcome to attend in their cultural attire.

More than 150 people came together to share their heritage, learn from one another and celebrate the rich diversity that makes our communities so special. The event raised close to £2,300 for the Trust's charity, Caring Minds, helping to support projects that improve the wellbeing of patients, service users and colleagues across the Trust.

Dr Jordan Daniels played the kora, an African instrument, as well as the keyboard, and Dr Humaira Aziz and Dr Ananta Dave recited poetry. Professor Subodh Dave, President of the Royal College of Psychiatrists, also supported the event, for which we are very grateful. Dr Ananta Dave kindly donated the proceeds from signed copies of her book *An Agony of Hope*.

I am very grateful to my fellow organisers, Dr Supriya Dastidar, Dr Ramneesh Puri and Dr Shweta Mittal, and to my colleagues Sophie Pierro, Nicola Raybould and Louise John, who helped us raise money through the raffle on the day. Thank you to everyone who donated, volunteered and came from near and far to make the evening such a success.

We plan to hold this event regularly and would recommend similar events across the country. Together, we celebrated cultures, built connections and supported mental health, and we look forward to many more.

Dr Fabida Aria
Consultant Psychiatrist and Chief Medical Officer, Birmingham and Solihull Mental Health NHS Foundation Trust
TSIG Executive Committee member

Where Cultures Meet and Care Begins: Reflections on the BBPA Annual Conference 2026

On Friday 23 October 2026, the British Bangladeshi Psychiatrists Association (BBPA) brought together clinicians, trainees, academics, and community and faith leaders at Coram Campus, London, for our annual conference on Psychiatry, Leadership, Community and Human Rights. As a diaspora group within the Royal College of Psychiatrists' network, we exist because psychiatry works best when it understands the histories, languages, faiths and families of the people it serves. In a multicultural NHS, transcultural psychiatry is not a niche interest; it is everyday practice.

A place with a story

Coram Campus stands on part of the old Foundling Hospital estate. British Library records include a letter from 1762 concerning a legacy left to the hospital by Omichund, a merchant from Bengal. We turned this into a quiz question for delegates, because it reminds us that the relationship between Britain and South Asia is long, complex and sometimes painful. Remembering it honestly is part of cultural humility, which is where good transcultural practice begins.

What we explored

The programme brought together senior voices from the Royal College of Psychiatrists, including its President, Professor Subodh Dave, and its Dean, Professor Nandini Chakraborty. Professor Piyal Sen spoke on human rights in psychiatric practice and Professor David Taylor on optimising antipsychotic use. Trainees and early-career psychiatrists showcased their work, and Dr Erica Cini presented research on eating disorders among Bangladeshi people in the UK.

Bangladeshi women's mental health: from inequality to action

Chaired by Dr Ananta Dave, this session asked why some women reach services but do not recover at the same rate. NHS Talking Therapies data for 2022–23 were presented showing that 61.1% of Bangladeshi patients achieved reliable improvement, the lowest of any ethnic group, compared with 67.3% of White British patients, and that 8.2% of Bangladeshi women deteriorated, among the highest proportions of any group. These are outcomes, not access figures. They point to the need for language support, an understanding of stigma and family context, culturally sensitive care and women-led community outreach. Dr Shafia Khanum, Dr Momotaj Islam and Mr Riyadul Karim brought perspectives from NHS data, clinical psychology and health equity work, and Apsana Begum MP, Chair of the All-Party Parliamentary Group on Bangladesh, gave a keynote address linking the experiences of our communities to the decisions that shape services.

Psychiatry, faith and community

For many people, a mosque, church, temple or gurdwara is the first place they turn when they are struggling. UK research shows that Muslim faith leaders are a significant source of informal counselling, yet in a survey of 41 UK faith leaders fewer than half felt their training was adequate to recognise mental illness [1]. Our afternoon session brought mental health professionals and faith leaders together for collaborative learning, with Professor Swaran Singh, Ms Sufia Alam of the East London Mosque Trust, and Dr Hafza Iqbal and Ruqaiyah Hibell of the Markfield Institute of Higher Education. The principle was clear: faith-based support can complement clinical care, and training for faith leaders can strengthen links with NHS services and help to challenge stigma.

Human rights and the memory of last year

This conference followed our 2025 conference, Healing the Unseen Scars, which examined mental health responses to enforced disappearance. Professor Andrew Forrester and I have since published a call for research and action on its psychological effects on victims and families [2]. Loss, silence and trauma travel across borders and generations, and diaspora groups are often among the few places where such conversations can happen with cultural understanding.

What diaspora groups can offer transcultural psychiatry

- Start from the community. Partnerships with mosques, charities and community groups reach people who may never attend a clinic.
- Treat faith and culture as strengths. They are sources of resilience as well as of stigma.
- Count what is not counted. Outcomes by ethnicity and gender reveal inequalities that averages hide.
- Invest in early-career colleagues. A trainee showcase builds confidence, networks and future leaders.
- Work across diaspora groups. Shared learning strengthens every group and the College as a whole.



Delegates at the BBPA Annual Conference 2026, Coram Campus, London

BBPA is now a registered charity in England and Wales, recognition of more than a decade of work supporting British Bangladeshi psychiatrists, trainees and the communities we serve. It is also a reminder that culturally responsive care is built over years, through patient relationships rather than single events. Our thanks go to the conference team, volunteers, speakers and delegates. If your group or service is working on culturally responsive care, faith and mental health partnerships or community engagement, I would warmly welcome a conversation.

Dr Anis Ahmed
President, British Bangladeshi Psychiatrists Association
Consultant Forensic Psychiatrist and Clinical Lead in Psychiatry, Aston Medical School

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1. Meran S, Mason O. Muslim faith leaders: de facto mental health providers and key allies in dismantling barriers preventing British Muslims from accessing mental health care. Journal of Muslim Mental Health. 2019;13(2):23–44.

2. Ahmed A, Forrester A. Mental health challenges of enforced disappearances: a call for research and action. Medicine, Science and the Law. 2025;65(4):267–269.

CULTURE, THOUGHTS AND WORDS

Seeing Myself, Seeing You: Reciprocal Invitation in Systemic Practice

The elephant outside the room

I invite you to imagine a small door to a therapy room and, outside it, an enormous elephant waiting. It moves carefully so as not to knock anything over. You see it struggling but choose your words gently, calling out to others for assistance: "There's a very large client here, someone with an unusual body shape – could you help?" You avoid mentioning its size, its trunk and its great ears, thinking you are being kind. Yet the elephant pauses, pressing its head against the frame and wondering, "Am I not recognised? Do they not see me?" It remains halfway in and halfway out, uncertain whether it is welcome, still waiting for someone to name it and truly help it through.

This image captures how differences – especially those that are socially marked – may be politely but deliberately overlooked in the therapy room. Burt, Russell and Brooks (2016) highlight that race and culture remain among the most frequently neglected dimensions in professional counselling, whose foundations in the United States were developed largely within a White, middle-class context. When racism, stereotypes and historical oppression are ignored, Black clients, for example, often experience a sense of "invisibility": their lived experience and cultural identity may be misinterpreted, and anger may be pathologised rather than understood as a protective response. Such oversights damage the therapeutic alliance and risk misdiagnosis.

Burkard and Knox (2004) found that therapists high in colour-blind racial attitudes – the belief that race "should not and does not matter" – reported lower empathy and held African American clients, but not European American clients, more responsible for solving their problems. "Not seeing" difference does not create equality; it perpetuates invisibility and harm, just as the elephant remains stuck at the therapy room door.

Therapist reflexivity and the use of self

Therapists function as the central instruments of psychotherapy (Pereira et al., 2024), and their self-awareness is therefore pivotal. Multicultural competence – integrating awareness of one's own cultural values and biases with knowledge of clients' worldviews and culturally responsive skills – creates a therapeutic environment that feels safe and validating, particularly for clients from marginalised groups (Farook, 2019). The "use of self" refers to the deliberate and reflective integration of a therapist's own personality, experiences and feelings into clinical work to strengthen the therapeutic relationship (Baldwin, 2013).

Locating myself

I locate myself within multiple, intersecting contexts that influence how I see families and how families see me. I was born in Alexandria, Egypt, into a working-class Muslim family, my name itself signalling my parents' faith and heritage. I grew up by the Mediterranean, where the daily horizon became a metaphor for imagining "what lies on the other side".

During my university years I became politically active and took part in the 2011 Egyptian revolution. The thrill of solidarity, the euphoria of hope and the pain of losing friends, oppression and defeat taught me how power, voice and marginalisation operate within systems. These insights now inform my therapeutic stance when I consider who speaks, who is silenced and which stories are authorised in families.

Migration to the United Kingdom to train in psychiatry, and later in child and adolescent psychiatry, added new layers to my identity. Building a family without an extended kinship network led me to discover the importance of chosen families and informal support systems, and fuels my curiosity about how families adapt

across borders and negotiate loss, belonging and cultural transmission.

Seen through an intersectional lens, these experiences are interwoven strands rather than discrete chapters. In practice, I draw on this awareness to attend to both the visible and invisible aspects of clients' Social GRACES (aspects of difference such as gender, race, religion, age, culture and ethnicity), to situate problems within wider contexts and to remain reflexive about my own position of power and vulnerability. My task is to hold the therapeutic space responsively, creating conditions of safety in which differences can be voiced: seeing my patient while also making myself "visible" to them. The following case illustrates how a stance of "reciprocal invitation" – an openness that invites and is invited by the client – facilitated dialogue.

Case: N

N, a 13-year-old boy with severe ADHD traits and a learning difficulty, lived with his parents and older sister. His father, who struggled with English, had developed a reputation for being "angry with services". Yet beneath this anger lay language barriers and a deep wish to help his son, even to "cure" him. In his search for help, he had taken N to a private clinic for a form of brain stimulation therapy, and this had led to a safeguarding investigation that deeply affected the whole family.

After an earlier consultation in which the telephone interpreting line kept dropping out, I chose to meet the family without an interpreter, using clear, simple English and written information in their own language. The father was ambivalent about restarting ADHD medication, describing it as making N "slow", while the mother opposed it altogether. Both wanted N moved from his special school to mainstream education, believing the special school "doesn't teach anything". I gently reframed their view, explaining that N's calmer mood and reduced anxiety were linked to the removal of mainstream stressors, and reassured them that his delayed speech was a feature of his learning difficulties rather than a side-effect of medication.

Before the session, drawing on our shared Middle Eastern background, I had rehearsed how to acknowledge the value placed on education and the pressures families feel about their children's progress. After I had presented my rationale, the father surprised me. He looked at my wedding ring and asked quietly, "Married?" I nodded. "Children?" Yes again. Then he asked, "If he were your child, what would you do?" Without hesitation I replied, "I would start him on medication and keep him in the special school for now." He nodded, spoke to his wife in their own language, and turned back, saying, "I trust you." In that powerful moment, a shared experience I had not counted on – parenthood – was invited by the family and bridged our perspectives.

Conclusion

Seeing myself in the therapy room has deepened my capacity to see my clients. In working with N, consciously holding my own history, values and assumptions helped me to cultivate an environment of "reciprocal invitation": a two-way stance in which therapist and family invite and respond to each other, so that difference and similarity can be voiced without fear and acknowledged without conformity. In those moments, culture, generation, migration, trauma and parenthood were no longer invisible elephants at the door, but shared entry points for trust, meaning-making and change.

Dr Eslam Elmasry
Consultant Child and Adolescent Psychiatrist, Cardiff and Vale University Health Board



A Transcultural Life

I was born, you could say, into transcultural circumstances, in 1950. My businessman father espoused middle-class values and traditions; my maternal grandfather was a working-class labourer; and my mother had deliberately relinquished much of her original vocabulary and diction. Neither branch of my family was religious, yet I attended Church of England schools and received an excellent Christian education.

Navigating the subtle tensions between these three poles of experience gave me a chameleon-like ability to blend in socially with many kinds of people, including people from cultures very different from my own. This was good early training for a would-be psychiatrist, and for someone intent on exploring mental health and wellbeing through a prolonged enquiry into the wisdom teachings of a range of world faith traditions and cultures – an experiential journey as much as an intellectual one.

Travelling has helped. I have prayed at the Western Wall in Jerusalem and visited the Temple Mount, sacred to Islam; witnessed the *Sama*, the whirling dance of Sufi mystics in Anatolia; been welcomed in Hindu temples across India; eaten in the langar at the Sikh Golden Temple in Amritsar; climbed Mount Parasnath, sacred to India's Jain community; and spent three days at the Tibetan Buddhist festival at Hemis in Ladakh. Buddhist monks, in particular, have taught me much.

After qualifying in England, I trained in psychiatry in New Zealand and Australia before returning to the UK, eventually becoming a consultant in Brighton. One experience in Sydney was pivotal. Covering a Greek doctor's single-handed practice, where few patients spoke English, I had time to write and found myself asking what good mental health actually consists of. It is obviously much more than the absence of psychiatric symptoms.

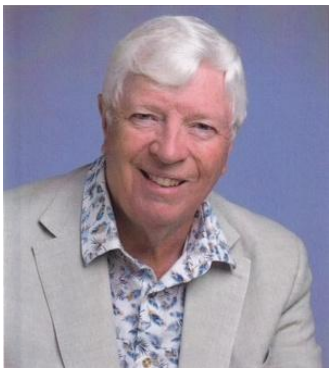
I arrived at a holistic scheme of five interlinked dimensions – physical, biological, psychological, social and spiritual – and later at an account of a natural process of emotional healing. Just as nature heals body tissues, so, in supportive conditions, it heals the painful emotions that follow losses and threats: anxiety reverts to calm, sadness to joy. This process leads gradually towards maturity, marked by less self-centredness and more humility, honesty, kindness, tolerance and forgiveness.

Importantly, these qualities seem to be shared across cultures, both religious and secular, throughout the world – a reminder of our common humanity in the desire for happiness and freedom from suffering.

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2. James Fowler (1995) *Stages of Faith: The psychology of human development and the quest for meaning.* San Francisco: Harper Collins.
3. Larry Culliford (2014) 'The Meaning of Life Diagram: a framework for a developmental path from birth to spiritual maturity', in the *Journal for the Study of Spirituality,* 4:1, 31-44.
4. A. Reza Arasteh (1965), 'Final Integration in the Adult Personality', in the *American Journal of Psychoanalysis*, 25: 61 - 73.
5. See the World Wide Wave of Wisdom (www.wwwow.net) for an elaboration of these ideas.

Dr Larry Culliford

Larry Culliford is a former consultant psychiatrist in Brighton, a co-founder of the Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group and the author of several books on happiness, spirituality and wisdom. He is a patron of the mental health charity 'Being Alongside' (www.beingalongside.org.uk), and the author of several influential books and papers on topics like happiness, spirituality, and wisdom. For more information, please visit his website (www.LDC52.co.uk)



My Personal Journey into Transcultural Psychiatry

Reflections on culture, language, beliefs and mental health across four countries

My understanding of transcultural psychiatry has been shaped not only by my medical training and professional experience but also by my personal journey across different countries, cultures and languages. Having been born in India, raised in Iraq, undertaken my medical internship in Nepal and established my psychiatric career in the United Kingdom, I have had the privilege of seeing how cultural beliefs, social traditions and attitudes towards illness influence the way people understand and respond to mental health difficulties.

My family moved to Iraq because of my father's employment, and we lived there for approximately 25 years. Iraq became an important part of my upbringing, education and cultural identity. The Iraq I experienced was a modern, progressive and relatively Westernised society, particularly in its approach to education, medicine and professional development. I studied medicine at Baghdad University, where teaching was delivered in English and the standard of clinical training was exceptionally high, but I communicated with patients in Arabic, which became a natural part of my clinical practice.

In the clinical settings in which I trained, patients generally described their symptoms in medical terms, and I did not commonly encounter explanations involving supernatural forces, witchcraft or possession. Such beliefs may have existed in the wider community, but they were not prominent in my own clinical encounters.

Nepal: different meanings for the same symptoms

My training was interrupted by the Gulf War, which prevented me from completing my internship in Iraq, so I travelled to Nepal to undertake it. There I encountered patients who attributed physical symptoms to black magic, curses or supernatural forces. Some sought help from traditional healers, astrologers or Tantriks, often before approaching medical services. These beliefs were not perceived as unusual by patients or their families; they formed part of a culturally accepted framework through which illness and suffering could be understood.

My experiences of mental illness in Nepal were particularly thought-provoking. Experiences that Western psychiatry might describe as auditory hallucinations were understood by families as communication from a goddess or evidence of divine possession. The grandiose beliefs sometimes seen in mania could be interpreted as divine instructions or manifestations of spiritual power. In some cases, these explanations reduced the perceived need for psychiatric assessment or medication, and families sought religious or traditional interventions instead.

As a young doctor trained within a biomedical model, I initially found these differences difficult to reconcile. With time, I came to appreciate that the same clinical symptoms can acquire profoundly different meanings depending on their cultural context, and that spiritual beliefs should not automatically be regarded as evidence of psychopathology. The important clinical questions are whether an experience is consistent with the person's cultural and religious background, whether it causes distress or functional impairment, and whether it forms part of a recognisable mental disorder.

Language and the NHS

After my internship, I moved to the United Kingdom to join my family, passed the PLAB examination and joined the NHS. My early experience presented an unexpected linguistic challenge. Although I had been taught medicine in English, I was used to speaking with patients in Arabic. For about six months, I found myself unconsciously translating conversations from English into Arabic and back again before responding, until this internal translation gradually disappeared.

This gave me a lasting appreciation of the additional cognitive and emotional demands faced by people receiving healthcare in a

language that is not their first. Language is not simply a means of conveying information; it carries emotional meaning, cultural associations and deeply personal experiences. Patients may struggle to describe psychological distress in a second language, particularly when discussing trauma, shame, unusual experiences or deeply held beliefs.

I now work as a consultant psychiatrist in a female-only inpatient assessment and treatment unit in Brent, one of London's most culturally diverse boroughs. For some of the women I see, mental illness carries significant stigma, not only for themselves but for their families. Others interpret symptoms through religious or spiritual beliefs, or fear admission, medication or the consequences of disclosing personal difficulties. Cultural expectations about women's roles, family responsibilities, marriage and autonomy can further influence the willingness to seek or accept treatment.

What I have learned

Culturally sensitive psychiatry does not mean accepting every cultural explanation uncritically, nor abandoning evidence-based treatment. It involves understanding the patient's own explanation of their difficulties, recognising the influence of family and community, and building a therapeutic relationship that respects cultural identity while addressing clinical needs. Equally, we must not assume that everyone from a particular cultural or religious background shares the same beliefs: each person is shaped by their education, upbringing, migration history, family relationships and personal values.

For me, transcultural psychiatry is not simply an academic discipline. It is the recognition that, although mental illness may have common clinical features across societies, the language through which suffering is expressed, the meaning attached to symptoms and the pathways through which people seek help are profoundly influenced by culture. Our responsibility as psychiatrists is not only to understand the illness but also to understand the person experiencing it.

Dr Mala Singh
Consultant Psychiatrist, Central and North West London NHS Foundation Trust



Through the Looking Glass: A Psychiatrist Between Two Cultures

Reflections on migration, professional identity and belonging

> *"A journey of a thousand miles begins with a single step." – Lao Tzu*

Down the rabbit hole

Three years ago, I moved from Pakistan to the United Kingdom, carrying a suitcase of belongings and a far heavier cargo of experience: years as a psychiatrist, medical educator and academic leader, and an abiding curiosity about the wider world. My career in Pakistan had been deeply fulfilling, and moving to Britain was never about leaving that identity at the departure gate. It was a chance to experience another healthcare system, widen my horizons and begin a new chapter. I often think of those early months as my own *Alice in Wonderland* experience. And what a Wonderland it was!

A Wonderland of small things

It began with the weather: the chilly mornings, the turning seasons and the forecast's remarkable status as a staple of conversation. Then came unfamiliar roads, shopping habits and social customs, each a small lesson in finding my feet. The NHS opened a world of its own, with its acronyms, electronic systems, structures and processes. Everything was different – not better or worse, simply different.

There is something fascinating about seeing a familiar profession through another culture's lens. Psychiatry remained psychiatry, but the systems, language and professional customs around it had changed. I was not starting from scratch; I was building on firm foundations in a different setting.

Reading between the lines

The most interesting discoveries, however, were about people. Coming from a setting where communication can be direct, I became fascinated by the subtleties of British conversation. "That's interesting" might signal genuine curiosity, polite disagreement or something else entirely. "Perhaps we could consider another approach" might be a suggestion, or a graceful way of saying no. Decoding the subtext became an essential skill.

Language is not merely vocabulary. It carries humour, expectations, relationships and meanings that are often understood without being spoken. Working in child and adolescent psychiatry added another layer: young people have their own idiom, shaped by generation, family, community and the wider world. I reflected on how culture influences not only what we say, but how we express distress, seek help and make sense of our experiences. As psychiatrists, we are trained to listen closely. Living between cultures taught me to listen with even greater awareness of context.

One foot in each world

A question has stayed with me: what does it mean to integrate into a new culture without being wholly assimilated by it? I wanted to understand and embrace British culture while remaining anchored to the values, traditions and experiences that had shaped me. Perhaps belonging is not a choice between two identities, but a matter of letting them coexist and enrich one another.

Migration also teaches us what we carry. Airline baggage allowances impose strict limits, and years of life must be distilled into a few carefully chosen belongings. Yet what matters most takes up no space in a suitcase: our education, experience, relationships, values and sense of self.

Strength in shared stories

In 2024, I spoke at an SAS doctors' event about joining the NHS. Afterwards, colleagues from many countries approached me with stories of their own. Our backgrounds differed, yet the similarities in how we had adapted to a new professional culture were striking – a reminder that international medical graduates bring not only clinical expertise but perspectives shaped by different healthcare systems and societies.

Those conversations spurred me to start a quality improvement project at East London

NHS Foundation Trust, exploring how to strengthen the experience of international medical graduates joining the organisation. Through surveys and discussions with colleagues, we identified opportunities to improve induction, peer support, mentorship and shadowing. Some changes have been introduced, while others remain works in progress – proof that personal reflections, once shared and examined collectively, can change an organisation for the better.

Two worlds, one story

I am grateful for the foundations I built in Pakistan and for the opportunities, colleagues and experiences that have enriched my life in Britain. Both cultures have made me who I am. For me, transcultural psychiatry is more than an academic interest. It is a way of approaching people with curiosity, recognising that our understanding of human experience is shaped by the cultures in which we live.

As for Alice, I am not sure I have found my way out of Wonderland. Perhaps I no longer need to. I did not have to leave my old world behind to find my place in a new one; I simply had to discover how the two could become chapters of the same story.

Dr Nadia Liaqat

Dr Nadia Liaqat is a child and adolescent psychiatrist with clinical and academic experience in Pakistan and the UK, and an Executive Committee member of the RCPsych Transcultural Psychiatry Special Interest Group.



Across Cultures, Within Myself: A Psychiatrist's Journey Through Two Worlds

At 29, I left India for the United Kingdom; at 42, I returned to India to be with my ailing parents. Between these two journeys lay thirteen years of working in the UK, marked by professional growth, personal change and encounters with different ways of understanding healthcare, relationships and the world around me.

As a psychiatrist trained in both India and the UK, I had imagined that my qualifications and clinical experience would prepare me well for working across cultures. Yet moving between countries was more than transferring knowledge from one healthcare system to another. It challenged my assumptions, reshaped my professional identity and invited me to reconsider what I had regarded as familiar or universal. Looking back, I realise how profoundly these two relocations have influenced my understanding of transcultural psychiatry, the importance of listening and the relationship between professional life and personal meaning.

Leaving, returning and learning to see differently

My first relocation was an exciting transition into a different professional and cultural environment. It meant learning new systems, adapting to different expectations and finding my place in an unfamiliar setting. Like many professionals who move countries, I carried with me the training, experiences and cultural values that had shaped my early career, while remaining open to new ways of working and thinking in the NHS.

When I returned to India thirteen years later, I was not simply coming home to the country I had left. I was returning with a different professional identity and a broader frame of reference. Honestly, this was the more difficult transition, perhaps because my sense of identity had grown stronger. Home was familiar, but I had changed. I found myself comparing and questioning practices and expectations that had once seemed self-evident, and I came to appreciate that neither familiarity with one's country of origin nor experience abroad guarantees effortless adaptation. Each transition required me to observe, question and learn anew.

Moving in both directions taught me that cultural adaptation is not a one-way process. I did not simply leave one culture behind and adopt another; I carried my experiences between worlds, continually reinterpreting what I knew and who I was.

When professional values meet different systems

One of the strongest influences on my professional philosophy in the UK was multidisciplinary working: bringing together different professional perspectives, sharing responsibility and developing a common understanding of a patient's needs. Back in India, I became more conscious of differences in organisational culture and professional priorities. Multidisciplinary collaboration seemed less prominent than I was used to, and I was struck by the importance attached to professional visibility and promoting one's work through the media.

Communicating our work can be valuable in raising awareness, advocating for mental health and sharing innovation. Yet I remain convinced that professional contribution must ultimately be reflected in the quality of care we provide, the teams we build and the difference we make to patients and their families. Over the past seven years, I have built a full multidisciplinary team at my institution. It took time, and it taught me the professional humility to think carefully about which values we wish to preserve and how we contribute to the environments in which we work.

On a personal level, family was a powerful source of belonging and resilience, but family expectations also complicated my experience. I learned to resist interpreting these experiences too quickly and tried instead to re-adapt. The more perspectives I encountered, the more important it became to listen before judging.

Spirituality: a professional interest and a personal journey

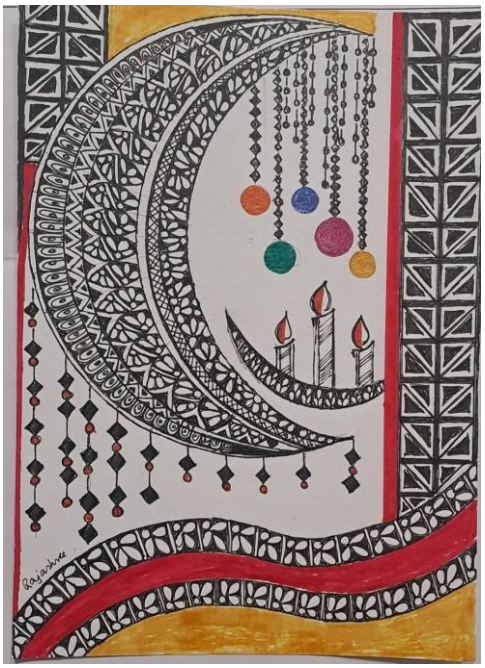
In this process of re-adapting, unlearning and learning, I found strength in spirituality, nature, service, contemplation and creative expression. My work with the spirituality sections of the World Psychiatric Association and the Indian Psychiatric Society deepened my interest in the relationship between meaning, connectedness and psychological wellbeing, and encouraged me to reflect on the place of spirituality in my own life. I found a personal avenue of reflection through mandala art.

Working with patterns, colours, symmetry and the gradual unfolding of a design around its centre invites me into a quieter space of concentration and reflection. For me, the process is as important as the finished painting: it encourages patience, attentiveness and a willingness to let the work develop gradually.

The mandala's relationship between its centre and its surrounding patterns offers a compelling metaphor for human identity. Our upbringing, culture, relationships, beliefs and professional experiences may pull us in different directions, yet together they form the complex whole that makes each of us unique. Moving between India and the UK has made this image particularly meaningful to me: neither experience cancels out the other, and both have contributed to the person I have become. I do not regard mandala art as a substitute for psychiatric treatment, nor do I assume it holds the same meaning for everyone; rather, it has helped me appreciate the place of creativity and contemplation in my own life.

Across cultures, within myself

My journey has taught me that belonging is not always a simple matter of geography. We may be shaped by more than one culture, carry different professional identities and continue to learn from places we have both left and returned to. Transcultural psychiatry is not merely about learning the customs or beliefs of different communities; it is about approaching each person without assuming that our own frame of reference is universal.



Mandala painting by Professor Ray-Bandyopadhyay

Sometimes the most important step towards understanding another person is to pause and listen more carefully. Sometimes it is to turn that same attention inward. Moving between two worlds has not given me all the answers, but it has taught me to ask better questions.

Professor Rajashree Ray-Bandyopadhyay

Professor Rajashree Ray-Bandyopadhyay trained in psychiatry in India and the UK and is Chair of the South Asian Division of the Royal College of Psychiatrists. Her interests include spirituality and mental health, postgraduate medical education and professional leadership.



Love, Unmoored

"Transcultural psychiatry is about fostering a deep connection and understanding between people from all cultures, all abilities and all parts of the world. Leadership that fosters such a culture is one based on love – the ability to hold people in our thoughts, give them our undiluted attention and celebrate their success. It is fundamental to providing high-quality healthcare. My poem is dedicated to the love that leadership calls for in these polarised times."

The land of your first breath, your first words,
The only place you have ever known,
Where your right to live was
As certain as the sun heralding the morn.
The land that you embraced as your own
To give the best years of your life,
Where you came with dreams untold
And waded your way through the strife.
Justice, democracy, a free press
Made you feel secure, tethered;
Opportunity beckoned you up its ladder,
Your spirit celebrated being free, unfettered.
An alien, uprooting wind now does blow
To whisper harshly, anew,
"The right to live in your homeland
Is shaped by your skin's hue."
The rank odour of colonialism,
Spread by the flag-shaped signs of division,
Whipped up by the spears of discrimination,
Seeps into the seams of the nation.
What autoimmune disease are we
Creating, where our internal organs
Are considered alien antigens
And blinded antibodies are attacking their own?
What is the colour of belonging?
Of hope and honour?
How suffocating the cost of breathing
Of lonesome labour?
But, as the country's mooring begins to fray,
Generous hearts bend into hooks that hold,
Help cool the scorched fields of hate,
Spread a salve on xenophobic wounds.
The sandbags of solidarity can stem
The rising flood waters of bigotry.
One step, one word, one hand at a time
Can build a bridge between us and them.
Love, unmoored,
Can gather a fresh headwind and vigour,
Bring the lifeboat of peace and liberation
Safely into a welcoming harbour.

Dr Ananta Dave
Consultant Child and Adolescent Psychiatrist
College Lead for Mental Health Equity, Royal College of Psychiatrists



From Disability to Determination: The Power of Language in Shaping Attitudes and Expectations

A personal reflection from a child and adolescent psychiatrist

As healthcare professionals, we are trained to diagnose, treat and care for patients, but some of the most valuable lessons we learn come not from textbooks but from the people we meet along the way. Working with patients with disabilities has been one of the most meaningful parts of my career. While working in the United Arab Emirates (UAE), however, my perspective was challenged by an approach in which individuals with disabilities are respectfully recognised as "People of Determination".

In 2017, the UAE introduced this term as part of its commitment to a more inclusive society that recognises the abilities, contributions and potential of people with disabilities. When I first encountered it, I was struck by its positive message. Rather than focusing on disability as a limitation, the term encourages us to see the individual beyond their medical condition. It made me ask: do we sometimes allow a diagnosis to shape how we see a person before we have had the chance to understand who they are? As a child and adolescent psychiatrist, I became particularly interested in how this language might influence the way parents perceive their children after a diagnosis of a neurodevelopmental condition.

Culture, language and disability

Working in a different cultural environment reminded me that our understanding of disability is shaped not only by medical knowledge but by cultural beliefs, social expectations and the language used within our communities. For some parents, a diagnosis of autism or intellectual disability brings relief and understanding. For others, it evokes sadness, anxiety or concern about how their child will be perceived within the family and wider community. Parental expectations are often influenced by cultural values surrounding education, independence, achievement and family responsibilities. The UAE's terminology offered an example of how a society can consciously try to reshape perceptions of disability through language.

What does your child expect from you?

Parents naturally imagine a future for their children: academic success, friendships, independence. When a child receives a developmental diagnosis, these expectations may be challenged. In my conversations with families, I often ask a different question: "Rather than focusing only on what you expect from your child, have you considered what your child expects from you?"

This invites parents to stop measuring their child against conventional milestones and to consider what their child needs to feel understood, supported and accepted. I encourage them to reflect on their child's strengths. What does your child enjoy? What makes them happy? What are they good at? These conversations can reveal aspects of a child that have been overshadowed by concerns about their diagnosis. The aim is not for parents to give up hope, but to let go of expectations that may not reflect who their children are, and to develop expectations grounded in their child's abilities, needs and potential.

I found it particularly rewarding to see families' attitudes change when our conversations shifted from difficulties to strengths. For some, this meant appreciating small developmental achievements; for others, recognising different ways of communicating, expressing affection, learning or interacting with the world. These changes did not remove the challenges families faced, but they helped create a more positive understanding of their children. Sometimes the most meaningful therapeutic change is not in the child, but in how the family understands and responds to the child.

Words are never neutral

My experience in the UAE reinforced the importance of understanding the cultural context in which psychiatric diagnoses are received and interpreted. The words societies choose reflect cultural values, influence expectations and shape attitudes towards

difference. However, positive terminology must be accompanied by meaningful inclusion and practical support. Children with disabilities should not have to demonstrate exceptional determination to deserve respect, acceptance or opportunities, and families should feel able to acknowledge their difficulties without believing this undermines their child's strengths. We must remain sensitive to how different communities understand disability, while recognising that individual preferences vary within every culture.

I have carried this perspective from my three years in the UAE into my NHS practice. Perhaps the most important question we can encourage parents to ask is not "How can I help my child become the person I expected them to be?" but rather "How can I become the parent my child needs and expects me to be?" For me, this captures the deeper meaning of moving from disability to determination: not simply changing terminology, but changing perspectives.

Dr Saman Khan

Dr Saman Khan is a Consultant Child and Adolescent Psychiatrist with over 20 years' experience in the UK and internationally, in public and private practice.



Beyond Representation: Supporting Black Women in Psychiatry

I am a fifth-year medical student at the University of Nottingham and the founder of Black Grls In Psych (BGIP), an initiative that encourages and supports Black women interested in a career in psychiatry. The idea came from an interest in representation within psychiatry and in how race, culture and lived experience shape Black people's mental health and their experiences of mental healthcare.

Mental health practitioners can sometimes lack the cultural awareness needed to recognise how racialised experiences and cultural context shape a person's distress. When this happens, experiences risk being misunderstood and invalidated, which harms the therapeutic relationship and can contribute to poorer outcomes.

The wider picture

The 2018 independent review of the Mental Health Act 1983, *Modernising the Mental Health Act*, highlighted longstanding "profound inequalities" for ethnic minority communities in access to treatment, experiences of care and outcomes, and identified crucial gaps in trust between service users and providers [1]. A 2025 photovoice study of racialised experiences of detention found that, despite early help-seeking, poor coordination of care meant compulsory admission was not always prevented; participants described not being believed, dismissive or hostile responses and unnecessary police involvement [2]. In the year to March 2023, Black people in England were 3.5 times as likely as White people to be detained under the Act (228 compared with 64 detentions per 100,000 people) [3].

Together, these findings highlight the need for services that recognise cultural context, address racial inequalities and provide equitable care. Increasing the number of Black mental health practitioners will not solve this alone, but it is a valuable step.

Barriers in the workforce

Black women may face distinct barriers to mentorship, opportunities and career progression because of the intersection of race and gender, often discussed as misogynoir. NHS workforce data show that across all staff roles, Black and minority ethnic women report the highest rates of discrimination from managers, team leaders or colleagues, followed by Black and minority ethnic men, a pattern that has persisted since at least 2015 [4]. In a UK survey of 109 Black psychiatrists, 57.8% had experienced workplace microaggressions, 40.4% bullying and 37.6% harassment, and 32.1% had considered leaving [5]. These findings underline the importance of supporting Black women to enter, progress and remain in psychiatry.

What BGIP does

Grassroots initiatives can help address some of these barriers by providing educational resources, opportunities and peer support throughout the training pathway, and so help tackle the "leaky pipeline": the loss of people from under-represented groups at successive career stages.

BGIP shares information about the specialty, application guidance, educational content and opportunities such as national student psychiatry conferences, abstract calls and summer schools. It has grown into a team of six Black female medical students who share their experiences of psychiatry placements and electives, helping to make the journey into psychiatry feel less isolating. Because many students have limited exposure to the range of careers within psychiatry, our "Finding Your Fit in Psychiatry" series explores different subspecialties, and our interview series asks psychiatrists about their career journeys and advice for students.



The Black Grls In Psych team (left to right, top to bottom): Gloria, Mary, Kiah, Afusat, Chineye and Mameh

In future, I hope to establish a peer mentoring programme connecting Black women interested in psychiatry with those already working in the specialty, so that they can share experiences and navigate the challenges of progression together. My aim is to see the number of Black female psychiatrists grow across the UK and beyond, and to help more Black women see psychiatry as a career in which they can thrive.

Gloria Akinpelu
Fifth-year medical student, University of Nottingham
founder, Black Grls In Psych

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Finding Room for Ourselves: A South Asian GP's Reflections on Midlife

I have been a GP for more than 23 years, and one of the things I have valued most is the trust women place in me. Working in the community, I have listened to women trying to care for everyone around them, often with very little room left for themselves. As a South Asian woman born and brought up in the UK, now in midlife myself, some of those conversations feel increasingly familiar.

I find myself thinking about how much we carry, but also about who we are underneath it all. When we have spent years being someone's daughter, partner, mother or doctor, do we always know what we want for ourselves? And when we begin to work it out, how comfortable do we feel saying it?

These questions have become part of my own reflections and my developing work as a coach. Recently, I began interviewing South Asian women in midlife, including friends and colleagues, to understand their experiences and what support they might find helpful. This is exploratory work rather than a formal research study, and these conversations cannot represent all South Asian women.

What has been really interesting is how each woman has brought a different perspective. For some, the hardest part has been managing work alongside children and ageing parents. Others have spoken about bereavement and missing someone who would ask about their day and properly listen. Some want more space for themselves; others are enjoying stronger relationships, greater confidence and the freedom this stage of life can bring. It would be easy to hear something familiar and assume we are all having the same experience, but that would mean missing so much.

When a woman wants something different

One question I keep coming back to is what happens when a woman starts to want something different – to develop her career, start a business, look after her health or simply have an evening without being available to everyone. She may love her family and value everything she has, while still wondering where her own wishes fit.

A friend who is a consultant psychiatrist recently sent me a short video about the differences between our generation and those of our mothers and grandmothers. It made me reflect on how women may have been recognised and valued for sacrifice, and how that can influence what we expect of ourselves. Our mothers and grandmothers had ambitions and lives of their own, and their experiences varied enormously. But I wonder whether some of us have carried forward the expectation of always giving, while adding more that we hope to do: build a career, be an involved parent, keep family traditions going and take better care of ourselves. Sometimes we are trying to work out a way of living that we have not seen modelled closely.

If you have spent years trying not to disappoint anyone, saying no can feel surprisingly difficult, and when you try to protect some space, the guilt arrives. I think it is worth being curious about that guilt. Whose expectations are we trying to meet? Are they still being placed on us, or are they ones we have become used to placing on ourselves? There will not be one answer. Family circumstances, culture, faith, finances and relationships all play a part. Some women have considerable support and freedom; others face constraints that cannot be changed simply by becoming more assertive.

Culture in the consulting room

Years of community practice have taught me to leave room for what a woman may not feel ready to say at first. Culture can shape how distress is described: one woman may talk about her mood; another may begin with tiredness or poor sleep. Physical symptoms need proper assessment, alongside space to explore what else is happening, and I try not to assume what her symptoms mean.

These differences exist within communities too. Upbringing, language and previous experiences of seeking help all matter. Some women fear

judgement; others draw strength from family, faith and community. I have heard South Asian women say they would prefer to see someone South Asian because there might be less to explain. I understand that. But sharing a background does not mean I already understand someone's life, and these interviews have reminded me of that repeatedly.

For me, a holistic approach means being willing to look beyond my first explanation. There may be physical symptoms to assess, emotional difficulties to explore, practical pressures or questions about identity. Coaching, therapy and medical care have different roles; the support should make sense for that woman.

I am still learning through these conversations. They have helped me recognise parts of myself, appreciate experiences different from mine and think more carefully about the assumptions I bring into my work.

Dr Samila Asad

Dr Samila Asad is a GP with more than 23 years' experience and special interests in women's health and dermatology. She is also a coach with a developing focus on supporting South Asian women through midlife.



Culture, Dance and Wellbeing: Nurturing Resilience Through Community Engagement

As healthcare professionals, we recognise that health and wellbeing are influenced not only by clinical care but also by culture, identity, community and meaningful social connections. Alongside our medical careers, we have both been involved for over a decade with a sociocultural organisation that promotes diversity, inclusion and personal development through cultural events, arts and dance, teaching choreographed cultural dances to children and young people.

Cultural dance has been far more than a recreational pursuit. It has given young people opportunities to connect with their heritage, build friendships and develop self-confidence in a supportive environment. Young people who joined with limited confidence often became role models for newer members, mentoring younger participants. Public performances helped many to overcome anxiety, improve their communication and gain a sense of achievement, and the persistence needed to learn choreography often carried over into education, employment and community life.



Cultural dance performances by the group (faces blurred)

Participation has also fostered a strong sense of belonging. The group provided a space where young people felt accepted, supported and empowered, whatever their background. Families often became involved too, creating an intergenerational environment that strengthened social connections and mutual support. Many participants used performances to support fundraising events and community projects, developing empathy and an awareness of the needs of others.

We have been inspired by former participants who have carried these values into adulthood. Some have gone on to serve in youth leadership organisations and youth parliaments, advocating for young people in their communities. Others have founded or joined university societies that celebrate diversity and inclusion, creating opportunities for students from different backgrounds to connect and extending the benefits of cultural engagement to wider communities.

A transcultural perspective

From a transcultural psychiatry perspective, these experiences highlight the role that culturally meaningful activities can play in supporting mental health. Cultural practices can help people maintain a sense of identity while strengthening connections with family, peers and community. They offer opportunities for self-expression, social support and positive coping, all of which contribute to psychological resilience. For many participants, cultural dance became a source of stability, connection and pride during periods of change and challenge.

While healthcare services remain essential, communities possess important assets that help strengthen resilience and reduce social isolation. Community-led programmes that encourage participation, connection and belonging can build protective factors and promote positive mental health before difficulties become more significant.

Our backgrounds in general practice and psychiatry have shaped these reflections, reinforcing our understanding of the relationship between physical health, psychological wellbeing and the social and cultural contexts in which people live. We have come to appreciate that opportunities to build

resilience often arise long before someone seeks healthcare support. This work has allowed us to translate insights from clinical practice into community action, while our experiences outside healthcare have enriched our approach to holistic care. By celebrating diversity, fostering inclusion and creating opportunities for meaningful participation, culturally rooted community activities can help nurture resilient individuals and stronger communities for generations to come.

Dr Nkechinyere Eze and Dr Geraldine Odo

Dr Nkechinyere Eze is a GP in North East England with an interest in community wellness and health promotion. Dr Geraldine Odo is a Core Psychiatry Trainee in North East England with interests in transcultural and community-based approaches to mental health.





Bridging Cultures: Reflections of an International Medical Graduate in Psychiatry

My journey in medicine began in Bangladesh, where I completed my medical degree over 12 years ago. Like many international medical graduates (IMGs), I found that moving to the United Kingdom brought both opportunities and challenges. Adapting to a new healthcare system, understanding professional expectations and navigating cultural differences required resilience, patience and continuous learning.

While preparing for the PLAB examinations, I began supporting fellow doctors who were also working towards careers in the UK. What started as informal guidance gradually became voluntary teaching and mentoring. Having experienced the challenges of transition myself, I understand the value of mentorship and practical guidance, and throughout my NHS career I have continued to mentor newly arrived IMGs, helping them understand workplace culture, communication styles, professional expectations and the realities of working in the NHS. These conversations often extend beyond clinical work to confidence, wellbeing, career development and a sense of belonging within a new system.

The value of shared understanding

As an IMG myself, I firmly believe that international doctors are a valuable asset to the NHS. We bring not only clinical skills and experience but also cultural understanding and linguistic diversity. Working in multicultural communities in London, I have often found that patients appreciate speaking with someone who understands aspects of their culture, values, traditions or migration experiences. This shared understanding can help build trust and strengthen therapeutic relationships. Patients frequently feel more comfortable discussing sensitive issues when they feel culturally understood, which is particularly important in mental health services.

These experiences have reinforced my belief that transcultural psychiatry is not only about understanding patients from diverse backgrounds but also about recognising and valuing the contributions that a diverse workforce brings to the NHS. Working in CAMHS in North East London, I continue to learn from colleagues, patients and communities from a wide range of cultural backgrounds, and every interaction reminds me of the importance of cultural humility, curiosity and compassion.



The Shaheed Minar replica in Altab Ali Park, East London, a landmark of the British Bangladeshi community. Photo: Nicholas Jackson, CC BY-SA 3.0, via Wikimedia Commons

Challenging stigma

As a British Bangladeshi doctor, I have reflected on how cultural attitudes towards mental health can influence both patients and healthcare professionals. Within many South Asian communities, including my own, mental illness can still carry significant stigma. Conversations about anxiety, depression, neurodevelopmental conditions and psychiatric treatment are often difficult, and many people continue to suffer in silence.

I believe that one of our responsibilities as psychiatrists is to challenge these misconceptions and encourage open discussion about mental health. My commitment to psychiatry is also shaped by personal experience. I am not ashamed to acknowledge that I underwent an assessment and received a diagnosis of ADHD. Rather than viewing this as a weakness, I see it as an important part of understanding myself and others. It has given me greater insight into the lived experiences of many patients and reinforced my belief that seeking help is a sign of strength, not failure.

I remain grateful to those who supported me during my own transition into the NHS; their guidance inspired me to support others. By sharing our stories, normalising conversations about mental health and embracing cultural diversity, we can help reduce stigma and create a more inclusive and compassionate healthcare system, in which people feel able to seek support without fear of judgement.

Dr Ayesha Sumina

Dr Ayesha Sumina is a CAMHS Specialty Doctor at North East London NHS Foundation Trust. Originally trained in Bangladesh, she has a strong interest in mentoring international medical graduates, medical education and transcultural psychiatry.

Whose Childhood Counts? Culture and Adult ADHD Assessments

An adult ADHD assessment often begins with an unusual request: we ask someone to take us back twenty, thirty or even fifty years and explain what they were like as a child. However, I have become increasingly interested in another question: how much does the childhood we expect to hear about shape the one we recognise?

Our diagnostic standards rightly demand a careful developmental history. NICE calls for a full clinical and psychosocial assessment, supported by developmental and psychiatric history and observer information, rather than reliance on rating scales alone [1]. The Adult ADHD Assessment Quality Assurance Standard (AQAS) places similar emphasis on detailed clinical interviewing, real-life examples and corroborating evidence [2]. None of this is negotiable. The challenge is to apply these standards without assuming that childhood looked broadly the same for everyone.

Consider the familiar request for school reports. They can be enormously helpful, particularly for distant memories. Yet many adults have no reports to offer. Their records may have been lost, their education interrupted, or their schooling completed in another country. This is not unique to people who grew up outside the UK. The absence of a school report tells us something about the evidence available; it does not, by itself, tell us whether ADHD was present.

That distinction matters. We still need convincing evidence of childhood-onset symptoms, persistence, impairment and their occurrence across settings. We should pursue collateral accounts and records where feasible, weigh their reliability and be explicit when the history remains uncertain. Cultural awareness is not a reason to lower the diagnostic threshold. It is a reason to examine more carefully whether our usual methods give every patient a fair assessment against those standards.

Language can be just as revealing. An adult might remember being called “lazy”, “stubborn”, “careless” or “naughty”. Those words reflect an interpretation of behaviour, not a clinical description. I would want to know what the child actually did. Were instructions forgotten? Did tasks remain unfinished? Was the child repeatedly distracted, or were they resisting demands for other reasons? What happened at home compared with school? Unless we move beyond labels, we risk mistaking other people’s judgements for evidence.

We also need to understand what was expected of the child. In some households, obedience and academic success were paramount. In others, children took on substantial domestic or caring responsibilities. Families differed in how closely adults supervised homework, organised daily routines or responded to restlessness. A child who achieved good grades with intensive family support might have experienced significant difficulties that were largely invisible to teachers. Equally, poor attainment or disciplinary problems are not, in themselves, evidence of ADHD.

Collateral histories can illuminate these differences, but they are not neutral accounts. A parent may remember a child as perfectly well behaved, while the adult seeking assessment recalls considerable effort simply to meet expectations. Neither perspective should automatically be dismissed. The task is to explore what each person observed and how they understood it. NICE guidance on adult mental healthcare recognises the importance of understanding people’s own explanations of their difficulties, including cultural and religious perspectives [3].

We must also resist the temptation to treat culture as shorthand for ethnicity, nationality or faith. Two people from the same community may have grown up in very different households, and generations within the same family may interpret behaviour differently. As clinicians, we also bring cultural assumptions of our own: about what constitutes normal childhood behaviour, parental involvement, appropriate independence and convincing evidence. Those assumptions deserve scrutiny too.

Inattention, restlessness and difficulties with organisation may arise in the context of trauma,

anxiety, disrupted schooling, language barriers or other experiences. They can also coexist with ADHD. The question is not simply whether the behaviour resembles an ADHD symptom, but when it began, how consistently it appeared, what circumstances shaped it and whether another explanation accounts for it better. Good transcultural practice should make our differential diagnosis more rigorous, not less.

In practice, this may mean asking different questions before reaching for another checklist. What was a typical school day like? Who helped you get ready or finish your work? What happened when that help was no longer available? How did adults explain your difficulties at the time? These questions invite the patient to describe a life, rather than fit a memory into a predetermined account of childhood.

I would like this approach to feature more explicitly in adult ADHD training and supervision. Alongside diagnostic criteria, clinicians should have opportunities to examine the assumptions behind their conclusions. Services can help by making appropriate interpretation available and finding practical ways to obtain collateral information from relatives abroad, while recognising when it cannot be obtained. None of this replaces sound clinical judgement; it strengthens it.



A giant lattu (spinning top), a traditional toy, at an art festival in Kolkata. Photo: Salil Kumar Mukherjee, CC BY-SA 4.0, via Wikimedia Commons (bystander blurred)

If we want our assessments to be both diagnostically robust and equitable, we need to be willing to ask not only more questions, but sometimes different ones.

Dr Michael Akeju

Dr Michael Akeju is a Locum Consultant Psychiatrist and Medical Lead in an adult ADHD service in London, with a special interest in multidisciplinary education and ADHD service development.

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The Paradox of Connection: Migration, Identity and the Borders We Draw

Reflections on belonging, cultural exchange and the shared history of psychiatry

There is a peculiar paradox to the world we inhabit. Never before have we been so connected, so exposed to different cultures, ideas and ways of life. We celebrate the movement of knowledge and marvel at how interconnected our world has become. Yet when it comes to the movement of people, the conversation changes. Borders become sharper, identities more contested, and the language of difference begins to overshadow all that we share.

I find myself reflecting on this increasingly as debates about immigration, national identity, "the boats" and belonging continue to dominate public discourse. Somewhere between the headlines and the political rhetoric, it is easy to lose sight of the lived realities of migration: the hopes, sacrifices, uncertainties and search for belonging that accompany every journey. We often speak of migration as a contemporary challenge, a disruption to an otherwise settled social order. Yet the movement of people has been one of the defining features of human history. Civilisations have evolved through encounters, trade, migration and intellectual exchange, and scientific knowledge has travelled across continents, often becoming so embedded in its new surroundings that its origins are barely recognised.

A shared history of psychiatry

The history of psychiatry offers a fascinating counterpoint to contemporary debates about borders and belonging. Long before modern healthcare systems, different civilisations were developing their own understandings of the mind, distress and healing. In ancient India, Ayurvedic traditions, including the *Charaka Samhita*, explored the relationship between mind, body, behaviour and wellbeing. In medieval Persia and the wider Islamic world, scholars such as Al-Razi, Ibn Sina and Al-Balkhi transformed the understanding of emotional and mental disorders, drawing on and extending Hellenistic, Indian and ancient Near Eastern traditions; Baghdad is often cited as the home of one of the earliest dedicated psychiatric wards. Across West Africa, indigenous approaches to mental distress placed importance on spiritual beliefs, family relationships and communal life. Much later, the Nigerian psychiatrist Thomas Adeoye Lambo's pioneering Aro Village model brought community resources and modern psychiatric care into dialogue.

These traditions were neither identical nor without their limitations. Yet they remind us that the history of psychiatry has never belonged to one civilisation, culture or geography. Knowledge has travelled, been translated, challenged, adapted and enriched through encounters between different worlds. We readily acknowledge the value of ideas that have crossed borders, yet our conversations about the people who cross them can be considerably less generous.

Migration and the NHS

This feels particularly relevant within the NHS, an institution whose history and continued functioning are inseparable from the contributions of people who have travelled from across the world. From the Windrush generation, who helped build the post-war NHS, to today's internationally trained doctors, nurses and allied health professionals, migration has been woven into the fabric of British healthcare. These professionals have brought more than their qualifications: they have brought languages, cultural knowledge, different ways of thinking and perspectives shaped by experiences beyond these shores.

Migration is not merely the movement from one country to another. It is an ongoing negotiation between the familiar and the unfamiliar, between what we inherit and what we acquire, between adaptation and authenticity. There are visible adjustments of language, customs and professional expectations, but also quieter negotiations: the cultural references we learn, the parts of ourselves we emphasise or soften,

and the subtle calculations involved in deciding when to explain our differences and when simply to let them pass.

The ability to move between different worlds can cultivate adaptability, empathy and curiosity. But there can also be a cost to continually negotiating one's place. Belonging can become something to be demonstrated rather than simply experienced, particularly when acceptance appears conditional upon assimilation, contribution or conformity.

What we mean by belonging

This invites us to think more deeply about what we mean by diversity and inclusion. Diversity is often celebrated through its more visible expressions – food, festivals, languages, clothing – but equally valuable are the perspectives that challenge familiar assumptions and the insights that emerge when different ways of seeing the world meet.

For those of us who have lived between cultures, identity rarely fits neatly into the categories society uses to define it. Citizenship, ethnicity, nationality and belonging are often spoken of interchangeably, yet they describe very different aspects of human experience. For some, living between cultures creates a sense of being at home in many places; for others, it brings the unsettling feeling of being slightly foreign in all of them. More often, both coexist.

The need to belong is not simply a social preference but a fundamental component of psychological wellbeing. For many healthcare professionals who have crossed borders to live and work in the UK, belonging can feel both familiar and elusive. You can build a career, contribute to your community and call a place home, yet still feel never quite fully accepted.



Illumination from a Latin translation of a medical treatise by al-Razi (Rhazes). Public domain, via Wikimedia Commons

At a time when public discourse is increasingly preoccupied with borders and with who belongs, the history of our own profession offers an important reminder. Human progress rarely comes from drawing sharper boundaries around identity. More often, it emerges when people carrying different experiences meet, learn from one another and create something new. Some of our most important advances have come not from preserving the boundaries between worlds, but from crossing them.

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Kunst and Psyche: Creativity, Spirituality and the Birth of "Psychartica"

I scribbled verses
On a borrowed canvas from life,
And painted dreams on
A poet's palette.
I listened
To the stories of silences
And read your face
When words defied.
I lurked
In the galleries of the mind
And waited
For the seasons to change,
The colours to pour,
The rhythm to synchronise,
PHOTO: 02-sharma-ghalib.jpg | Mirza Ghalib (1797–1869). Public domain, via Wikimedia Commons
The music to enliven,
The expressions to gather,
The movements to stir
The world within –
As a world waited
For us to arrive…

From literature to psychiatry

I first encountered the work of Professor Nancy Andreasen in 2008, when I was navigating the parallel worlds of a medical aspirant and a literature aficionado. Andreasen, a professor of English literature, was inspired to study medicine to understand the link between creativity and the human psyche. Her story stayed with me like a guiding light, whether I was holding a scalpel in the dissection hall or taking my first psychiatric history.

Years later, in 2023, while co-authoring a book chapter on creativity and spirituality, I returned to her work and to a rich body of research exploring the intersection of *Kunst* and *Psyche* – art and mind. I found myself drawn once again to the questions that had first captured my imagination: what drives human creativity, and where do our ideas come from?

A creative act is often defined as something both new and appropriate to the task at hand: originality is necessary but not sufficient. Andreasen describes creativity as a process with three broad stages: identifying a problem, engaging with it through cognitive processes and producing something new. Yet creativity is rarely linear. It draws on memory, emotion, imagination and experience, and sometimes the most original ideas emerge from the spaces where conscious thought meets the less accessible dimensions of the mind. Perhaps this is where the artist and the psychiatrist begin to share a language.

Tapping into the unconscious

The journey of self-exploration usually begins with a question – "Where am I?" – followed by others: what is the purpose of existence, and is it guided by a higher power? In seeking answers, people may draw inspiration from religion, mythology, meditation, prayer or nature. Viktor Frankl wrote of a "spiritual unconscious", arguing that "the spiritual core, and only the spiritual core, warrants and constitutes oneness and wholeness in man" (Frankl, 1947/2011, p. 34). Creativity, too, may emerge from this dialogue between the conscious and the unconscious. Can creativity be a kind of "spiritual seeing"?

Creativity as an adaptive resource

Our responses to adversity are shaped by biology, personal experience, social circumstances and the resources available to us. Resilience is not simply innate; it can be nurtured through relationships, meaning-making and adaptive ways of responding to life's challenges. Creativity may be one such resource. Writing a poem, making music, painting or dancing may offer comfort, restore a sense of agency and help us find meaning in suffering. This does not mean that creativity is a substitute for psychological or psychiatric treatment, but it may be an important personal and cultural resource within a broader understanding of mental health.

The birth of Psychartica

Psychiatry strives to understand human experience through a biopsychosocial framework, yet in practice one perspective can come to dominate. A creative lens can broaden our view, drawing on philosophy, culture, literature and the arts. It was from this wish to create a space for dialogue across disciplines that Psychartica emerged: a platform where psychiatry could meet the humanities, bringing together literature, music, poetry, dance, visual art, philosophy and lived experience, so that clinicians, researchers, artists and people with lived experience could learn from one another. Psychartica explored four themes: creativity and mental health promotion; medical humanities in education and training; the arts in therapeutic practice; and resilience, growth and meaning through lived experience.

At its heart, Psychartica was an invitation to listen differently: to attend not only to symptoms but to stories, not only to diagnoses but to identities, and not only to suffering but to the many ways in which people express, negotiate and transform it.

My fascination with literature never disappeared; it found new contexts and new questions. A couplet by the celebrated Urdu poet Mirza Ghalib has been my mantra all these years: *"Ghar mein tha kya jo tera gham usay gharat karta? Woh jo hum rakhte the ik hasrat-e-tamir, so hai."* ("What did we have at home that your sorrow could wreck? All we had was a desire to create, and that is still there.")

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Madhubani Art: A Brief History, a Potential Tool for Mental Health Promotion, and a Personal Account

Madhubani art, also known as Mithila painting, is a folk art that originated in the Mithila region of Bihar, in India, and of Nepal. It was originally made with natural colours such as turmeric, coal and flower petals. Its principal themes have long been the beauty of nature – birds, fish, animals, people going about their daily chores, and deities. These paintings are used to decorate homes, not only in Bihar but throughout India, and they are considered especially important in marking auspicious occasions such as marriage and festivals in the Mithila region. The intricacies of the designs and their borders make the form distinctive.

There are five major styles: *Kachni*; *Bharni*; *Godna* (tattoo style), characterised by geometric and dotted patterns derived from traditional body art originally practised by marginalised communities; *Tantrik* (religious and spiritual); and *Kohbar* (themes of marriage and fertility). *Kachni* is a fine, intricate line style using a monochrome or limited palette, pioneered largely by the artist Ganga Devi from Madhubani district; *Bharni* uses bold black lines filled with bright, vibrant colours, often depicting Hindu deities.

The Mithila region comprises northern and eastern Bihar and the Terai of Nepal, bounded by the Himalayan foothills to the north, the Ganges to the south, the Mahananda to the east and the Gandak to the west. It includes the districts of Darbhanga, Madhubani, Sitamarhi, Samastipur, Saharsa, Madhepura, Purnia and Muzaffarpur, and is the heartland of the Maithili language, traditionally written in the Tirhuta (Mithilakshar) script. The region is united by language, art, mythology and distinctive traditions such as the *paag*, a unique headgear, and the *panji*, said to be the world's oldest and largest genealogical registry, used to regulate marriage and preserve ancestral lineages, as well as local delicacies such as *makhana* (fox nuts) and *dahi chura* (yoghurt with flattened rice). The art is rooted in ancient culture and tradition and has been practised primarily by women. Indian mythology, including the Ramayana, holds that the form began when King Janak of Mithila commissioned artists to paint the walls of his palace for the marriage of his daughter, Sita, to Lord Rama. For several centuries women have painted the mud walls, floors and courtyards of their homes during weddings, births and major festivals, using natural dyes applied with matchsticks, twigs and fingers.

Madhubani art came to wider notice when the British colonial officer William G. Archer saw murals on the damaged walls of the earthquake-struck Mithila region in 1934. In 1965, after a severe drought, the government aid worker Bhaskar Kulkarni and the cultural activist Pupul Jayakar encouraged local women to paint on handmade paper and canvas as a means of livelihood. The art has since moved from domestic walls to international exhibitions and public infrastructure, including Indian airports, railway trains and roadside murals. A dedicated Mithila art museum was established in Japan in 1982 by Tokio Hasegawa in Tokamachi, Niigata Prefecture; it holds the largest international collection of Madhubani art and serves as a hub for promotion and for archiving important works. In 2007 Madhubani painting received a Geographical Indication (GI) tag, Bihar's first, under the intellectual property framework.

Research has pointed to a number of therapeutic benefits: mindfulness; enhanced attention and concentration; grounding, as symmetrical, rhythmic strokes and repetitive patterns can help to lower anxiety; the use of colour, natural dyes and traditional motifs to help process emotions such as grief, burnout and stress; and increased self-esteem, as completing a complex piece can bring a tangible sense of fulfilment and accomplishment. These observations have been supported by heritage art studies at Drexel University and in correctional settings such as Mandoli Sub-Jail, which have reported a positive impact on the psychological wellbeing of inmates. Large randomised controlled trials specifically mapping Madhubani artwork onto physiology and neural pathways remain an ongoing area of

research. A study published in a pharmaceutical journal on women artists in Madhubani district reported that 81.66 per cent of respondents experienced a significant boost in psychological empowerment, building a positive self-image and gaining longer-term self-confidence (K. Savitha et al., 2020). Another study has suggested that structured visual folk art can function effectively as a mindfulness-based intervention. Field studies in well-known artists' hubs such as Jitwarpur have explored how the regular practice of Madhubani art can offer a coping mechanism against socio-psychological constraints (October 2022). The Indian Council of Medical Research and the All India Institute of Medical Sciences (AIIMS) have been working to integrate traditional art-based interventions into mainstream community mental health treatments.

I am Roopam Kumari. My native place is in the district of Darbhanga, Bihar, in north India. I have been practising Madhubani art for the last year or so, and I have personally witnessed its benefits in improving my focus and attention, and the calming and relaxing effects of drawing and painting. It took almost a month to complete an A4-sized work of human figures, but the process itself is soothing and enjoyable, and the finished piece brings an immense sense of fulfilment, increases self-esteem, fosters a sense of self-efficacy, and even builds connection among people who love and appreciate art, whether or not they practise it themselves. It makes us aware of a collective consciousness: all of humanity, and the non-human world, held in a bond of love and togetherness. I am in love with Madhubani paintings, and they have made me an artist, which I can proudly share with my colleagues. At first I was hesitant to share my work, as I felt this was my personal, spiritual, meditative path; but, strongly feeling its benefits myself, I could not resist.

I would urge every person to know about their heritage and folk art. Folk art can play a part in the recovery of people living with mental illness, and in day-to-day life it can help us to cope with stress and to build resilience. It is my dream to include folk art such as Madhubani painting in the treatment of people who experience mild, moderate and severe mental illness, so that they too may reap its benefits in daily life.

Roopam Kumari

I have made my painting on A4 paper, using the *Kachni* and *Bharni* styles, acrylic colours, a paintbrush and a waterproof black gel pen. It depicts a normal day, perhaps a morning, in rural India, in which two women, friends, in beautiful, vibrantly coloured *lehenga* and *choli* (blouse), go to collect water from a public well in a mud pot (*matki*), in the midst of nature, flowers and birds. They use this household chore as an opportunity to ventilate their emotions, support each other, show warmth and socialise. Borders in Madhubani painting hold a special value and add beauty to the whole.



Madhubani painting by Roopam Kumari, in the *Kachni* and *Bharni*

styles, depicting two friends collecting water.

NEWS

DiGo Talks: an international psychiatry learning community

DiGo Talks is an online community founded by Dr Divyam Goswami, a Senior Resident in Psychiatry at PDU Medical College, Rajkot, India, and co-hosted by Dr Bhavya Bhansali. It brings together people from 17 countries through regular webinars and an ongoing chat group, with the aim of helping colleagues learn from others whose training and practice differ from their own.

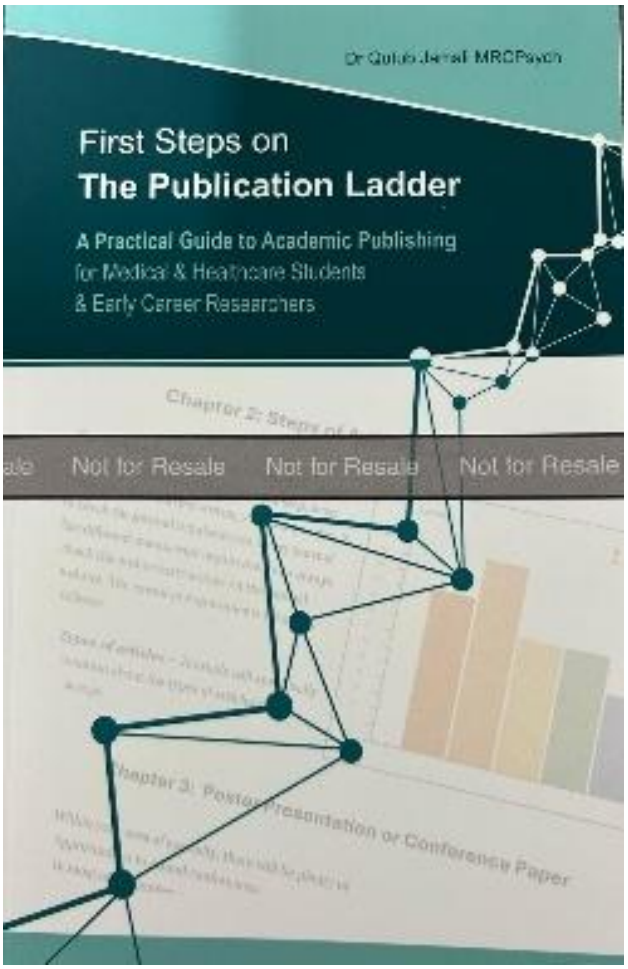
Recent webinars have included "Storytelling in psychiatry – the art and the science" with Professor Nandini Chakraborty, Dean of the Royal College of Psychiatrists (12 July 2026), and a comparison of the psychiatrist's role in the Indian and Australian legal systems with Dr Andrew Wilson, alongside sessions on intellectual disability, suicide prevention, eating disorders, adult ADHD and treatment-resistant depression. Colleagues interested in sharing experiences from their own settings or contributing to a future session are welcome to get in touch with Dr Goswami.



DiGo Talks webinar poster, 12 July 2026

New book: First Steps on the Publication Ladder

Dr Qutub Jamali has published *First Steps on the Publication Ladder: A Practical Guide to Academic Publishing for Medical and Healthcare Students and Early Career Researchers*. The book offers a step-by-step guide to research methodology, literature searching, data analysis and getting published, and is aimed at medical students, resident doctors and early career clinicians.



First Steps on the Publication Ladder by Dr Qutub Jamali

FUTURE EVENTS

Transcultural Psychiatry SIG Autumn Conference 2026 – Beyond Borders: Advancing Transcultural Psychiatry Through Equity, Innovation and Global Collaboration

The TSIG Autumn Conference will take place online on 27 November 2026, 9:00am–4:30pm. The programme includes a keynote by Professor Dinesh Bhugra on geopolitical determinants of mental health, plus sessions on AI and mental health across cultures, culturally informed formulations, working with interpreters, and research in transcultural psychiatry, with speakers from the UK and internationally. Fees: £119 (non-members), £90 (consultants), £66 (higher resident/SAS doctors), and £42 (core residents, medical students, foundation doctors, and subsidised and retired members). Bookings close at 2pm on Thursday 26 November. A recording will be available to registered delegates for three months. 1 CPD point per hour of content, subject to peer approval.

Book here: https://www.rcpsych.ac.uk/events/conferences/detail/2026/11/27/default-calendar/transcultural-psychiatry-sig-autumn-conference-2026---beyond-borders--advancing-transcultural-psychiatry-through-equity--innovation-and-global-collaboration

RCPsych International Congress 2027, 14–17 June 2027, Glasgow, UK

The Royal College of Psychiatrists' International Congress 2027 will be held from Monday 14 to Thursday 17 June at the Scottish Exhibition Centre (SEC Glasgow), Exhibition Way, Glasgow G3 8YW. The call for main programme proposals closed at midnight (BST) on Sunday 25 October 2026; outcomes will be confirmed by Friday 15 January 2027. A call for poster presentations and Cultural Fringe sessions will open later, with poster submissions expected at the end of 2026. Registration opens early in 2027; no closing date has yet been announced. Full details are on the official Congress page: https://www.rcpsych.ac.uk/events/international-congress/congress