Transcultural psychiatry

Special interest group

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Transcultural Psychiatry Special Interest Group (TSIG)

Newsletter, Summer 2024

TSIG Editorial Team

Content:

Message from the TSIG Chair

Dear all,

Welcome to our newsletter. Transcultural psychiatry continues to gain interest, both with our members and within other areas of our college. Many RCPsych events have had transcultural psychiatry and culture related topics, such as cultural Intelligence and cultural inclusion added to their programmes. In addition, medical school psychiatry societies and trainee psychotherapists have contacted us, to organise talks on transcultural psychiatry, as they have started to recognise the importance of being cultural savvy when working with patients.

The TSIG has also been having webinars which have been well received, and we are currently planning more to come. So, if you would like to contribute or have suggestions about specific topics, please do not hesitate to contact us.

We feel transcultural psychiatry really should be a golden thread of all psychiatry. Without an understanding of each individuals culture and how this influence people's understanding and experience of mental illness; and without genuine curiosity from professionals and development of trust, how can we provide the best care our patients deserve. Because of this, we will continue to promote transcultural psychiatry, and the benefits of adopting a transcultural approach. seeing you at the Congress special interest session drop in.

If you are interested in learning more about transcultural psychiatry, we would like to invite you to our next TSIG conference will take place on September 11th, at the RCPsych premises in London, in which we would also invite delegates to dress in attire that reflects their culture, as this will be a great way to learn about each other and celebrate our cultures. However, if you can't attend, please join us at this year RCPsych's International Congress in Edinburg, where we will hold a special interest session drop where we can meet, chat and interchange ideas related to the fascinating world of transcultural psychiatry.

Dr Fabida Aria

Notes from the editor

It seems the wait has been long, but with the temperature starting to increase, I think we can finally welcome this year's summer. This is exciting not only because we will be finally able to enjoy some time under the sun, but also because it will be packed with very interesting events, including the RCPsych International conference, and more importantly, our annual TSIG conference, which we hope you can join us on September 11th. Now, while we look forward to future events, it important to also look back to the work many members of the transcultural SIG committee have done, as many of our members not only took part on event focused on topics associated with transcultural psychiatry, but also work on projects, and wrote very interesting pieces, which we are very proud to share with you, in this, 2024 summer edition of our newsletter.

In this edition of the TSIG newsletter you will read about a few events, in which members of the TSIG committee organised or took part, not only to welcome international medical graduates (IMGs) to a trust in West London, aimed to improve the wellbeing of those IMGs new to the country; but also to promote the elimination of violence against women and girls; supporting survivors of war and conflict-related gender-based violence; and addressing health disparities associated with income, education, and housing, which are determinant in shaping health outcomes.

In this newsletter, you will also find three very interesting pieces focused on topics associated with transcultural issues. First, we have a very interesting, and reflective piece by Dr Shamiya Nazir, on how learning disability can be address from a transcultural point of view, and how by getting to know our patients, learning about their backgrounds, and making small cultural adjustments, their experience within mental health services can be dramatically improved. Then we have a very interesting discussion of a case of *Folie a Deux*, in which Dr Muhammad Sayed Inam, describes how two young patients, who were engaged at some point in their lives, developed similar psychotic symptoms, associated with the end of their relationship. Finally, we have a very interesting editorial article written by Sohini Banerjee and Arabinda N Chowdhury, focused on adopting a culturally competent approach and 'cultural Justice' which can help reduce health care gaps and cultural barriers, and in which differences in race, culture, religion and other social aspects can be better understood, acknowledged and respected, hence improving our interactions and care.

We know there is still much more to do, but overall, we hope you find these pieces interesting, engaging, and more importantly inspiring, to adopt transcultural psychiatric approach, as we strongly believe, this can only help improve the care we offer to our patients, and why not, improve our job satisfaction, which is also key for our practice. To be culturally savvy, is to be aware of how our culture and context influence who we are and how we interact with our world.

Dr Emmeline Lagunes-Cordoba

Past TSIG activities and events

Report on International Medical Graduates (IMGs) Induction at West London NHS Trust on 15.1.2024 for TSIG newsletter

IMGs are the backbone of NHS and constitute over 30% of medical workforce in NHS. As a newly arrived IMG understanding the working of NHS and workplace culture can be daunting. IMGs are heterogeneous, often skilled, have experience of working in a different health system, rich, diverse culture and life experience which can potentially be an asset to NHS. However, it is well established that IMGs face several barriers in career progression in NHS.

IMG doctors are disproportionately represented in complaints to General Medical Council (GMC). More recently, it is recognised that there is a need for induction programme specific for IMGs in addition to Trust induction. The College has published "A guide to living and working in the U.K. for International Medical Graduates". Around the same time in 2022, GMC published "Welcoming and valuing IMGs-A guide to induction for IMGs recruited to the NHS".

Both Dr Santosh Mudholkar and Dr Ali Syed, IMGs themselves and established Consultants in NHS were recently appointed as IMG Leads for West London NHS Trust through Health Education England (HEE), London. Dr Mudholkar and Dr Syed developed the idea of bespoke Induction programme for IMGs and co-hosted the event with General Medical Council (GMC) on Mon 15th January 2024 at St. Bernard's Hospital, Southall, Middlesex UB1 3EU.

This event was attended by new and existing psychiatric trainees, Medical Training Initiative (MTIs), Staff and Associate Specialist (SAS) doctors, established Consultants who had qualified from several countries in Asia, Africa, Europe and South America. Dr Derek Tracy, Chief Medical Officer along with Dr Daniel Andrews, Director of Medical Education, West London NHS Trust welcomed IMGs. Dr Mudholkar and Dr Ali set the ball rolling by giving a personal account of their own IMG journey from being an overseas trainee to becoming and thriving as Consultant in U.K. This was followed by a talk by Dr Imrana Putoroo, Chair, Psychiatric Trainee Committee (PTC) who highlighted how the College can support IMGs and Dr Andrews gave an overview of psychiatry training, exams and career progression. In the second half of the programme Dr Nicky Goater, Deputy Medical Director and Responsible Officer talked about Revalidation and Appraisal. This was followed by an interactive session by Ms Kelly Tully, GMC Regional Liaison Advisor, Northwest London. The GMC session included simulation audio-visuals for different doctor-patient clinical interactions highlighting ethical issues such as patient confidentiality, consent, professionalism and professional boundaries.

We received excellent feedback from attendees who valued the in-person meeting and networking opportunity. We are now planning our next IMG induction for August 2024 focussing on transcultural issues.

Dr Santosh Mudholkar and Dr Ali Syed
IMG Leads West London NHS Trust

Exploring Health Disparities: Insights from a Research Colloquium

From May 4th to May 7th, 2024, the American Psychiatric Association (APA) convened its annual research colloquium, drawing together experts from across the field to delve into the pressing issue of health disparities. Against the backdrop of an increasingly diverse and complex healthcare landscape, the colloquium provided a timely platform for researchers, clinicians, and policymakers to exchange insights and strategies for addressing disparities in mental health and beyond.

The colloquium kicked off with an array of keynote addresses and panel discussions, setting the stage for in-depth exploration of the multifaceted nature of health disparities. Speakers highlighted the interplay of social, economic, and environmental factors in shaping disparities in mental health outcomes, emphasizing the need for comprehensive and inclusive approaches to address these challenges.

Throughout the event, researchers presented their latest findings on disparities in mental health access, diagnosis, and treatment, shedding light on disparities based on race, ethnicity, gender identity, sexual orientation, and socioeconomic status. Attendees gained valuable insights into the underlying mechanisms driving these disparities, as well as innovative interventions aimed at promoting equity and improving outcomes for marginalized populations.

One notable highlight of the colloquium was the emphasis on community-based research and participatory approaches to addressing health disparities. Presenters shared success stories from collaborative initiatives that engaged community members as partners in research design, implementation, and dissemination, underscoring the importance of centring the voices and experiences of those most affected by disparities.

As the colloquium drew to a close, participants reflected on the opportunities and challenges ahead in the quest for health equity. While progress has been made, much work remains to be done to dismantle systemic barriers and create inclusive healthcare systems that meet the diverse needs of all individuals.

The colloquium served as a melting pot of ideas, where researchers from diverse backgrounds presented their findings and engaged in discussions aimed at unravelling the complexities of health disparities. Topics ranged from disparities in access to healthcare services based on socioeconomic status to the impact of race and ethnicity on health outcomes.

One of the key takeaways from the colloquium was the recognition of the multifaceted nature of health disparities. Presenters underscored the interconnectedness of various social determinants, such as income, education, and housing, in shaping health outcomes. Moreover, discussions emphasized the importance of adopting a holistic approach to address these disparities, one that recognizes the intersectionality of factors influencing health.

Dr Hasanen Al-Taiar, consultant Forensic Psychiatrist, Forensic TPD. Medical Member HM Tribunal Service, The Oxford Clinic, Littlemore Mental Health Centre.

Day of Elimination of Violence Against Women and Girls (EVAWG)

The Universal Peace Federation (UPF) UK, a non-governmental organization holding General Consultative Status with the Economic and Social Council of the United Nations, hosted an event on November 28th, 2023. December 9th, 2023. This occasion coincided with the '16 Days of Activism' initiative, spanning from the United Nations (UN) Day of Elimination of Violence Against Women and Girls (EVAWG) to Human Rights Day on December 10th, 2023. The event took place at the House of Commons of the UK Parliament, featuring a diverse array of esteemed speakers who delivered impactful and insightful presentations aimed at promoting constructive action and fostering dialogue.

The UPF and the UN, continue to play a pivotal role in addressing and combating violence against women and girls. Despite extensive global efforts, incidents of EVAWG have been on the rise, presenting a deeply concerning trend that underscores the urgent need for continued and enhanced advocacy and action.

I was honoured to be invited by Margaret Ali, Director of UPF, to participate as a speaker at this significant event. It was a profound privilege to contribute to this critical dialogue and to be part of a movement striving for a safer, and more equitable world.

Mr. Robin Marsh, General Secretary of UPF, delivered the closing remarks. The distinguished roster of speakers included Duchess Nivin Elgamal of Lamberton, Patron of UPF-UK; Tabitha Morton, Executive Director of UN Women UK; Lady Anne Welsh, author, entrepreneur, philanthropist, and CEO & Founder of Painless Universal; Bernie Davies, TEDx Speaker, author, and award-winning Diversity, Equity & Inclusion expert; Shaun Bailey MP, Member of the House of Commons for West Bromwich West; and Keith Best TD MA, former MP, Chair of UPF-UK, and former Chair of the World Federalist Movement. The participants were from diverse cultural background including mental health professionals, educators, policymakers, community leaders and members of public.

The event was expertly moderated by Baroness Verma and supported by Margaret Keverian Ali, Director of UPF. Speakers presented compelling research evidence and shared personal experiences to underscore that violence against women and girls is not merely a violation of their physical integrity but an affront to their dignity, rights, and the principles of equality and justice. The invisible scars left by such violence often remain etched in the soul and subconscious, continuing to haunt survivors long after physical wounds have healed. The enduring impact can manifest as lingering anxiety, persistent depression, psychological difficulties and trauma. The significance of understanding the cultural nuances of mental health conditions and the complexities of addressing ethnic diversity in a globalized world was emphasised.

The UN research spanning 161 countries reveals that 30 percent of women aged 15 to 49 reported experiencing physical and/or

sexual violence by an intimate partner or family member in the year preceding the survey. Globally, it is disheartening that one in three women experiences gender-based violence.

The speakers emphasised that our responsibility extends beyond treating the consequences of violence; we must also focus on preventing the conditions that lead to such devastating effects. The Princess of Wales, Kate Middleton's project on Early Childhood, which includes appointing experts like Dr. Trudi Seneviratne, Registrar at the Royal College of Psychiatrists, to advise her on early childhood initiatives, was highlighted as a significant example of proactive efforts.

The event served as a tribute to the dedication towards shaping a future where the rights and dignity of every individual are honoured. In summary, it underscored the vital role of collaboration and collective action in nurturing communities where equality and respect form the bedrock.

Dr Saima Niaz, consultant psychiatrist
Camden and Islington NHS Foundation Trust.

Speaking From Silences: Addressing Transcultural Traumas of Women Survivors of Gender-Based Violence from War in Humanitarian and Refugee Settings through a Trauma-Informed Perinatal Care Approach.

In a promising sign that the mental health impacts of conflict are being recognised by non-psychiatry focused specialities, I was invited to give one of the keynote presentations for the Royal College of Surgeons in Ireland a few months ago. I presented on the meaning for trauma-informed care awareness and approaches for surgeons engaged in humanitarian health efforts and treating survivors of conflict-related gender-based violence. The opportunity presented a valuable space for critiquing the mental health needs of women requiring surgical treatments in conflict settings, regardless of whether their clinical status was a result of gender-based violence or not. The current perception of trauma-informed care is heavily centralised within obstetric and gynaecological surgery but women survivors of gender-based violence incur all kinds of health needs, and it is important for surgeons to be aware of the potential areas for further traumatisation given the vulnerability of a surgical setting in recreating powerlessness through lack of autonomy and agency of the body during a prolonged period of exposure.

This work builds on a collaborative project with Dr. Rodney Reynolds, a medical anthropologist focusing on practices wellbeing, community, and belonging. We are exploring the ways that trauma-informed perinatal care needs to respond to women's experiences of war, and the ways that war impacts mental health. We are particularly focussing on pregnant refugee and asylum-seeking women in the United Kingdom, a sub-population who are situated in vulnerable circumstances because of the marginalisation and silencing of the ways women suffer—and survive—in war. These women deserve a refuge in their mental health as well as a safe land to find a new home. To achieve this, we are advocating for a transcultural psychiatry analysis of the trauma endured by women survivors of conflict-related gender-based violence and to determine clear messages for psychiatrists and other clinicians to collaborate and bridge existing gaps with obstetrics. The need for promoting healing during the transformative process of pregnancy is greatly significant, not just for maternal and child outcomes, but for the wellbeing of how a woman survivor of war and violence may experience and remember a new state of being and body.

Dr Ayesha Ahmad & Dr Rodney Reynolds

Open invitation

We welcome the work done by diaspora organisations, and we hope to have member from more diaspora organisations to share summaries of their events. We would love to add them to our newsletter to help promote the excellent work they do in the UK and abroad and help inspire our readers and learn more about transcultural psychiatry.

Culture, thoughts and words

How does psychiatry address learning disabilities culturally?

Approximately 1.5 million people in the UK have a learning disability (How common is learning disability, no date). It is certainly not a small number. When considering psychiatric treatment for this population group, do we consider cultural differences? Is it possible that learning disabilities become the sole identity of individuals and that we often forget their origins, beliefs, and the cultures in which they grew up in the family home as children?

There are not many years of experience I have in psychiatry and with learning disabilities. However, in this short period, something caught my attention. During the mandatory training I underwent called 'Oliver McGowan Mandatory Training on Learning Disability and Autism', I did not notice much diversity. According to a national ethnicity fact sheet released on 23rd June 2022, 3,570 people from Asian ethnic groups per 100,000 people, 5,125 people from Black ethnic groups per 100,000 people, 4,042 people from White ethnic groups per 100,000 people, 7,569 mixed people per 100,000 people, and 7,797 others per 100,000 people accessed mental health, learning disability and autism services from the NHS (Use of NHS mental health, learning disability and autism services, 2022). In the absence of awareness of the cultural identity of service users with learning disabilities, can or will service providers tailor their treatment plan accordingly?

Let me illustrate this point with a case example. I am using a fake name to protect the service user's identity. Chike is a 19-year-old man with a mild learning disability. He was referred to the learning disabilities psychiatry team due to his ongoing irritability, aggressive behaviour, and refusal to eat. He was physically and verbally aggressive towards his support workers/carers: throwing food and plates at staff, hitting staff, and staring them down intimidatingly. After investigating the issue and gaining collateral information, it became evident that his behaviour was triggered at a particular time of the day. It was generally at mealtime. For the remainder of the period, he displayed no agitation or aggression. He gets along with staff and other residents. Interestingly, he remained calm on the days when his family brought him home-cooked meals. So, the question becomes, did food play a role in this difficult behaviour? The answer is yes. Having ruled out psychosis and other major psychiatric disorders, the care plan was to implement dietary changes based on his preference and to follow up in a few weeks after the dietary changes were implemented. And magic happened. Within two weeks, his difficult behaviour had been resolved.

Let us take a look at another example. Once again, I am using an anonymous name. Tina is a 37-year-old woman with moderate learning disability, epilepsy and bipolar affective disorder. With the help of medications and an overall care package that included supported living and a range of activities, her mental condition was stable. Suddenly, her mood shifted down. Eventually, she began staying in bed most of the time, skipping activities that had previously brought her joy. When the recent change in life was discussed during the psychiatry interview, it was found that the care staff used to take her to church regularly. In addition to attending church services, she enjoyed reading the Bible and participating in

church singing. Later, it was replaced with another fun activity. It was found that her unmet religious need was the precipitating factor for her relapse. As a result of reestablishing church activity and reviewing her medication, she was in a much better state at the follow-up visit.

In psychiatry, we consider four perspectives: the disease, dimensional, behaviour and life story (Peters et al., 2012). Therefore, the life story of a person with a learning disability must not be overlooked. The reason for this is that by obtaining a thorough understanding of the person's life story, we can serve their cultural and religious needs and tailor their psychiatric care accordingly.

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Special thanks to:
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"A tragic love story and Folie a Deux"

A 19-year-old girl was taken to my mental health clinic two years ago. She suffered from psychiatric issues. Her parents stated that as soon as her romantic relationship abruptly ended, she developed mental health problems. The girl's parents forced her to end her four-year-long secret romantic relationship with a boy because of the disparity in their socioeconomic level.

The girl's guardian noticed that once the affair was ended forcefully, she began to suffer psychological issues such as hearing her fiancé's voices, seeing him sleeping in her bed, wandering around her, and whispering. Her parents thought that marriage would improve her psychological difficulties; therefore, they decided to wed her to someone else.

But after marriage, girl's psychiatric problems deteriorated rather than improved. As a result, her marriage was on the verge of ending. For the first several months, the young girl was treated by local quacks and religious figures but did not improve. She was diagnosed as Schizophreniform disorder and treated successfully with antipsychotics.

Two years later, another young man of 24 years visited my chamber. He has been acting strangely for a few weeks. He often hears a girl's voice whispering and beckoning to him. He regularly noticed the female walking about his bedroom. The young man remarked that the girl who is continually talking, whispering, and wandering next to him is looks like his ex-fiancé.

The young men's father also stated, "A few years earlier, a girl from the neighbourhood experienced the same mental illnesses. Your treatment has left her completely symptom-free, so we rushed to you as soon as we heard of it."

Interestingly, I learned and was perplexed by the fact that the young girl I treated two years ago, and the young men who was currently coming to me for the treatment, were both past lovers. The young men disclosed a important information: after their passionate relationship ended, the two of them had been secretly speaking over the phone on different occasions. The girl also frequently shared her psychiatric problems with the young men. The young men was then diagnosed with schizophreniform disorder and treated with antipsychotics, which led him to show improvement.

After evaluating this case, what conclusions might we make?

1. Were psychological issues between the two of them dormant while they were in love?
2. Love kept both of their mental problems buried. Does a breakup result in an outbreak of mental symptoms? Because they both had mental health issues, their brain chemistry was similar, and they fell in love and continued in a romantic relationship for around four years?
3. Because they both had mental health issues, their brain chemistry was similar, and they fell in love and continued in a romantic relationship for around four years?
4. Are the people who fall in love psychologically ill?
5. Should long-term romantic relationships not be forced to end abruptly ?
6. Forceful marriage is not the solution to any psychological issue.
7. If their relationship were permitted to continue, what would be the mental outcome of their offspring?
8. The young man stated that since the end of their romantic relationship, the two of them

had often been secretly talking over the phone. So is it a folie a deux?

9. If it is Folie a Deux, mental links between the primary and secondary cases necessary.

10. Folie a deux may occur even if the primary and secondary cases stay apart for an extended period of time.

Conclusion:

Even distantly sharing mental symptoms without living close together might lead to shared psychosis, or Folie a Deux, if there is an emotional tie present. Because, as seen in this case, after the termination of their romantic relationship, from the beginning of the girl's illness. to the divorce, they both spoke secretly over the mobile phone on occasion, and the boy developed psychotic symptoms right after the female had. Given this, it may be concluded that the girl is the primary case and the boy is the secondary case.

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Article

Cultural diversity and mental health

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Abstract: Culture gives context and meaning of distress and directs help seeking. Current mental health practice is transcultural in nature because of the wide cultural diversity of both professional and client groups. So cultural sensitivity of mental health professionals is a mandatory requirement otherwise the cultural difference between the service provider and the consumer may compromise service access for patients from other cultures. Culturally competent approach and 'cultural Justice' reduces health care gaps and cultural barriers and ensure best practice model where racial, ethnic, cultural, spiritual and social diversity is understood, acknowledged and respected.

Why the study of culture and its clinical application is important in mental health training and service? Mental health and illness is a set of subjective experience and a social process and thus culture plays a crucial role in clinical presentation, assessment, treatment planning and compliance. In the era of globalization and mass-migration, the practices of clinical guidelines in cross-cultural mental health assessments and diagnosis, and imposition of cultural determinants of public health policy, make the domain of cultural psychiatry more broad, significant and challenging in a multicultural world.

The Universal Declaration of UNESCO (2001) on 'Cultural Diversity' focuses on: (a) the diversity of people's backgrounds and circumstances is appreciated and valued, (b) similar life opportunities are available to all, and (c) strong and positive relationships should exist in the workplace, schools and in the community and society. Consideration of cultural diversity is a key issue in mental health because it influences the mental health service quality to ethnic minority communities (Bhui & Bhugra, 2002).

Culture refers to the shared characteristics, belief systems, values that a group of people commonly shape their norms, customs, practices, social rituals, behaviours, psychological processes, organizations, language and the material objects created by members of a given group that are often inherited by the next generation (Schafe, 2006). Apart from social relationships, economics, religion, philosophy, mythology, scriptures, technology and several other aspects of life all contribute to culture. It is not a static concept but a dynamic one that is in a state of constant change and flux and may be transmitted from one generation to the other. Here, the term culture is used as a substitute of ethinicity to accentuate the focus on an individual's/group's values. It is not a single entity, but involves many components and may be affected by national, regional, gender, class and individual issues. Culture impacts the way health (both physical and mental) and illness is understood, coping mechanisms, health

seeking behavior including methods of treatment, approach to protective and remedial measures, outlook towards health-care providers and expectations of the health care system.

Changing demography and migration

In recent years, migration (both internal and external) of people from one state to another (from countries) has contributed to considerable global intercultural linkages. Migration is a social process in which a person unaccompanied or accompanied by others moves to one geographical from another for economic, political, educational, social or for some other reason. These increased human movements across borders within and outside a country have lead to multiculturalism, a phenomenon reflecting cultural diversity within a society (Howarth & Andreouli, 2013).

Globalization and wide-spread political unrest, wars and conflicts in recent decades stimulated a sharp rise of migration globally. Migration to a new cultural-social milieu involves difficult acculturation process and cultural adjustment and thus has profound effects on cultural identity of the migrant cohort (Bhugra & Becker, 2005). Following are the few important cultural impacts of migration that need clinical assessment in cultural formulation.

- *Cultural identity*: Culture is a key factor in personal and social identity. It is the identity or sense of belonging to a group. The usual cultural identifiers are place, gender, history, nationality, ethnicity, language, religious faith, and aesthetics.

- *Migration and Cultural identity change:* adjustment and incorporation of host cultural norms, values, ethics and social-political rules causes rupture of external and internal 'cultural envelope' of the person and thus leads to profound identity changes which often leads to loss of cultural identity, alienation and acculturative stress and influence intra-group or interfamilial code of cultural transmission (Wiese, 2010).

- *Acculturative Stress*: refers to the psychological, somatic, and social difficulties that may accompany acculturation processes.

- *Deculturation or Cultural Uprooting*: Deculturation results when members of nondominant cultures become alienated (either by accident or by force) from the dominant culture and from their own minority society. It is a culture loss without replacement and may results in increased stress and psychopathology.
- *Cultural bereavement:* experience resulting from of loss of social, structure, cultural values and self-identity in the new cultural environment (Eisenbruch, 1991).
- *Diaspora*: is the movement, migration, or scattering of people away from an established or ancestral homeland. The term Diaspora carries a sense of displacement and a hidden hope or desire to return to homeland. They relate their identity with the culture of their homeland.
- *Culture shock*: is the difficulty in adjusting to a new culture that usually occurs during visiting a new place or during a short-term sojourn (international students). The usual

symptoms and signs are general unease, irrational fears, difficulty with sleeping, anxiety and depression, preoccupation with health, and home sickness.

- Migrant's Mental health: Different studies of post-migration stress has demonstrated increased rate of depression, schizophrenia and PTSD (Bhugra et al, 2010). The process of migration may include a feeling of displacement, estrangement and separation which in turn could give to stress and mental illness (Bhugra, 2004).

People of any age, religion, geographical location, race, ethnicity, socio-economic background, political ideology and culture may be affected by mental health problems. Knowledge and awareness about the diverse effects of culture and society on mental health, mental illness and mental health services is crucial for developing mental health services that are sensitive to the cultural and social contexts of racial and ethnic minorities. Hence, it becomes all the more important to adopt a culturally sensitive approach when rendering mental health service to people from diverse cultural settings.

Box 1: Cultural influence on Illness- perception

In clinical setting, understanding the client's view about their distress helps the assessment process and the treatment plan. Different cultures express the distress in different forms. For example, some Indian housewife may have at least three layers of explanation about her depressive episode, viz. punishment by God; results of bad deeds (*Karma*), and physical weakness and thus more keen to consult a spiritual healer rather than taking tablets from an allopathic doctor. Following issues are important in illness perception:

- *Idioms of Distress:* It is used to describe specific illnesses that occur in some cultures and are recognized only by members of those societies as expressions of distress. Example: the term 'nerve' which is used in many societies to designate both physical pain and emotional discomfort? In some culture, distress is expressed by 'somatisation': people complain of physical symptoms which are mainly caused by emotional or mental anxiety or stress.
- *Disease and Illness:* Disease, a biological construct, represents the manifestations of ill health in response to some pathological process and is translated into nosological descriptions of signs/symptoms under medical framework. Illness, a socio-cultural construct, having a symbolic nature, and primarily represented by the subjective, emotional, behavioural, interpretative and communicative responses of the affected individual.
- *Explanatory Model of Illness (EMI):* Patient's illness beliefs influence their symptom formation and degree of disability. Explanatory Models are the perception about a sickness and its treatment that is employed by all those engaged in the clinical process (Kleinman et al., 1978). Weiss (1997) further developed this construct into different clinical sets of Explanatory Model Interview Catalogue (EMIC) for different cultural and clinical groups. Explanatory model is a very useful clinical tool in mental health and in medicine.
- *Religion and spirituality:* Different cultures have diverse religious and spiritual beliefs, which contribute not only to form the cultural identity but also influence health

including mental health. The therapeutic aspects of religious/spiritual values and customs may be a source of support at the point of crisis.

- *Help seeking behavior:* The preferred treatment or help-seeking depend on the patient's (or family members') explanatory model of illness. The illness perception and its consequent presentation (somatically, behaviourally or affectively) direct who should be consulted. In fact, for many mental patients (or even in physical illness) the primary help-seeking is from traditional healers. This aspect of treatment preference should be clearly elicited and if the traditional or indigenous healing practices pose no health hazards, may be skillfully combined in the treatment negotiation to strengthen the treatment compliance.

Variation between care seeker and provider

Earlier, health care professionals and care seekers were primarily from the same ethno-cultural group with differences in social class, education and gender. However, in today's era mental health services must take into account ethno-cultural variations in patient and health professional backgrounds. These conditions necessitate conscientious attention to cultural insight and expertise on a number of dimensions including cultural background, gender, gender preference, age, language preference and fluency and religion.

Evaluation and Investigations

In order to make valid clinical and psychological assessments, the tools used should linguistically, conceptually and culturally appropriate. The use of standardized 'Western 'assessment instrument is not always desirable. For several years, the contribution of culture in the articulation of psychological symptoms remained unacknowledged (Ware & Kleinman, 1992). It was as late as the 1990s that the profound impact of culture on people's experiences of sickness/illness was recognised (Arrendondo et al., 1996). Efforts by cross cultural researchers bore fruit when the American Psychological Association in 1993 provided guidelines to practitioners working with various cultures and ethnic groups. The guidelines urged health professionals to incorporate multicultural and culture specific awareness, knowledge and skills into their practice. The Association also recommended practitioners to be aware of their own cultural values and prejudices; be aware of the individual/group's world view and apply culturally appropriate intervention strategies (Arredondo et al., 1996). Beliefs about the causality of illness range across the natural world, social world and every cultural/ethnic group may identify this differently. Culturally informed insights would enable the practitioner to deliver improved services.

A substantial body of research related to transcultural psychiatry has evaluated epidemiological findings across cultures. The International Pilot Study of Schizophrenia and the Determinants of Outcome study that followed from it had profound impact on psychiatric diagnosis and classification. The cultural validity of the WHO supported multi-centric studies of schizophrenia was challenged by medical anthropologists. Acknowledging the limitations of the study, the DSM IV task force constituted an advisory committee to ensure cultural dimensions were included in psychiatric diagnosis (Weiss, 1997).

There is considerable evidence that demonstrates that culture impacts perception of health (both physical and mental) and illness. Not only are there different views among different

ethnic groups and cultures across and within nations about what constitutes health and illness, these dissimilarities in perception play an important role in the management of the illness. One such difference pertains to the notion of causation of disease/illness. This could vary from beliefs in the bio-medical model, possession by spirits/ghosts; imbalance of yin/yang, energies/doshas (Ayurveda: Vata, Pitta, Kapha); the evil eye, black magic or flouting taboos including changes in perception such as categorisation of homosexuality as a mental disorder until 1974.

Culture moderates the way individuals and groups cope with challenges of daily life and more to severe adversity. Not only are there cultural/ethnic variations in the types of stressors that individuals/groups experience, but the appraisal of stressors also differs, as do the options of responses to stressors.

Culture can account for variations how people communicate their symptoms and which ones they convey. Some characteristics of culture may underlie culture-bound-syndromes- a set of symptoms more common in some societies than in others. Furthermore, culture influences whether people seek help in the first place, the nature of help-seeking, types of coping styles and social support and how much stigma they attach to mental illness. Culture also shapes the meanings that people impart to their illness. Users of mental health services, whose culture differ between and within groups, take this diversity to the service locale.

The culture of the patient, also referred to as the user of mental health services, affects many characteristics of mental health, mental illness, and patterns of health care utilization.

The representations of symptoms of common and severe mental disorders tend to be similar globally. However, culture bound syndromes which are typical of particular ethnic groups seem to be an exception.

One of the influences of culture on mental illness is the way patients narrate their symptoms to their clinicians. There is considerable variation in the expression of distress across cultures. It is well documented in research that Asian patients are more likely to report somatic symptoms than their Western counterparts. Also, they are less inclined to discuss emotional symptoms. However, on further inquiry, they admit having emotional symptoms (Lin & Cheung, 1999).

Cultures also influence the connotation imparted to illness, the ways in which individuals interpret their subjective notions of distress and sickness (Kleinman, 1988). Cultural connotations of illness have consequences in the sense if people are prompted to seek treatment, coping mechanisms, availability of social support, site of help seeking (family, friends, hospital, priest/temple, indigenous/traditional healer etc), pathways of care, adherence to treatment and prognosis.

Mental illness is a product of the synergistic interaction between genetic/biological, psychological, social and cultural factors. While there are consistencies in the prevalences of certain mental disorders across the world, nevertheless there are considerable divergences too. For e.g. the prevalence of schizophrenia, bipolar disorder and panic disorder is almost similar throughout the world.

It appears cultural and social circumstances weigh more heavily in the causation of depression. A study conducted by the National Institute of Mental Health (NIMH) in 1998

reported a variation in the prevalence rates of major depression from 2% to 19% across nations. Research has indicated that heredity plays a significant role in disorders like schizophrenia and bipolar disorder as compared to depression, post traumatic stress disorder (PTSD), suicide where social and cultural factors (poverty, violence etc) are more important.

Cultural competency training

In recent years, increase in the number of patients who are culturally distinct from that of the clinician embodies new challenges for providing quality mental health services. In addition to competence in practicing psychiatry, inclusive training in cultural and ethnic issues is warranted. Cultural competence training should be made an integral component of medical training. Cultural competence underscores the recognition of patients' cultures and then develops a set of skills, knowledge, and policies to deliver effective treatments. Cultural competence conventionally comprises institutional and clinical techniques of overcoming barriers to ensure effective mental health services to immigrant and ethnic minority patients. A brief cultural competency checklist can assist the health professional in appraising their capability for transcultural mental health work.

Box 2: Why Cultural Competency is Important for Health Professionals?

The increasing cultural diversity of recent era demands the delivery of culturally competent services. Health professions should have adequate cultural awareness (Chowdhury, 2011), the lack of which may be devastating and may lead to:

- ✓ **Miscommunication**: Patient-provider relationships are affected when understanding of each other's expectations is missing. The provider may not understand why the patient does not follow instructions: e.g., why the patient takes a smaller dose of sleeping medicine than prescribed (because of a belief that modern medicine is "too strong and may damage heart").

- ✓ **Rejection:** The patient may reject the provider even before any one-on-one interaction occurs because of non-verbal cues that do not fit expectations. For example, "The doctor only nods his head. Doesn't he listen me seriously?"

- ✓ **Cultural Distance**: It is the gap between the culture of two different groups, such as that between the culture of institutions/clinician and the service user or their families. Mental health service delivery faces this challenge especially to reach the ethnic minority clients (Littlewood & Lipsedge, 1988).

Cultural Justice

In recent years another concept within the domain of mental health that is gaining popularity is the notion of Cultural Justice. Cultural Justice envisages ‘fairness in relation to cultural and demographic information’. Along with cultural competency, cultural justice aims at providing

fair and effective services to all irrespective of their cultural, ethnic background. Cultural Formulation (CF) devised by DSM5 (DSM5, 2013) is a safety protocol to safeguard the cultural diversity of mental health clients. It provides a systematic method of considering and incorporating sociocultural issues into the clinical formulation and treatment planning.

Conclusion

Cultural differences undoubtedly influence various aspects of mental health including perceptions of health and illness, coping styles, treatment seeking patterns etc. Additionally, communication, use of cultural and linguistic interpreters, the nature of cultural competency and other cross-cultural trainings are important considerations for mental health practitioners and policy makers. Mere mainstreaming of mental health services will be ineffective. Research indicates mental health services that incorporate the western biomedical and the indigenous approaches in culturally diverse settings are more competent in providing effective care. While cultural variations do pose their own set of challenges, nevertheless they also present numerous prospects of working in effective ways towards positive mental health.

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Future events

Transcultural Special Interest Group Annual Conference 2024, RCPsych. September 11th.

Join us at our 2024 TSIG annual conference which is planned to be a face to face event. Please add this date to your calendar and join us to hear great talks, focused on transcultural psychiatry.

RCPsych International Congress 2024, June 17th – 20th, Edinburgh, UK.

The RCPsych International Congress will go back to Edinburgh this year, so, we hope to see many of our TSIG friends there, so, please come and say hello at the SIG stand, and at the SIG lunchtime Fringe session on Tuesday 18 June.