CULTURAL DIVERSITY
AND MENTAL HEALTH
A Souvenir for 24th National Conference of Indian Association for Social Psychiatry (NCIASP) 2017

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Uddip Talukdar
Cultural diversity and mental health
Das S, Talukdar U, editors

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EDITORIAL
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Shyamanta Das, Uddip Talukdar

Psychiatry changed over time; for the better, of course! We are moving towards a converging path, where inclusiveness is the call of time. Needed in this road is the incorporation of cultural and geographical requirements, with a special emphasis on reaching out to the unreached.

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Putul Mahanta

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CHAPTER II
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Prosenjit Ghosh

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Pinaki Chakravarty

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CHAPTER IV
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Usha Sharma, Bidula Sarmah

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evidence-based measures to prevent cervical cancer. Age old beliefs, customs, and traditions that marginalise girl and women are the hindrances. Commonest cancer of women in India is cervical cancer. Assam tops the list of sites where cervical cancer is most prevalent. In Kamrup Urban district, cervical cancer is the second most common cancer. Favourable attitude positively influences mental health of high risk population.

CHAPTER V
Dissociative disorder: a cross-cultural journey
Krishan Kumar, Vikas

We live in increasingly interdependent world that is gradually getting smaller. Global migrations and electro communications of intercultural exchange have impact on economic, political, psychological, social, and spiritual awareness of the cultural diversity. At every stage of mental illness, course and outcome of mental health problems are influenced by cultural issues. It is pertinent to understand the cultural milieu of patient, as it can help to understand the patient and his psyche which influence the disease and healing process. Across all over the world, it is believed that dissociative experiences take place due to three main reasons: due to stress, socio-religious belief system, and importantly, cultural factors. It is often assumed that dissociation across different settings involves underlying psycho-physiological mechanisms. However, there is uncertainty in current literature about the mechanisms and functions of dissociation which varied across cultures. Present article is an attempt to unfold the cover of cultural aspect in the prevalence, symptomatology, and treatment of dissociative disorder across different cultures.
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Mexico moves from the phase of infectious-contagious to chronic degenerative diseases; mental illness being prominent among the later. While mental illnesses are of major concern, but the allocation of budget does not reflect that. Migration is taking its toll on mental health in the North Mexico. City-centric mental healthcare services fail to do justice to the population as a whole. Persons with psychosocial disabilities, LGBT, children and adolescents are special populations that demand more attention.
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CHAPTER X
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Today’s world is a global village with growing number of multicultural societies. The cultural milieu in such society is relatively more dynamic, and brings unique challenges to mental health and mental health professionals. Also, each culture has its own strength, and domination of any individual culture can deprive members from benefit of values of other cultures, which can be of therapeutic importance. Perception and interpretation of some human behaviours can be dissimilar in different cultures, and line between normal and abnormal behaviour becomes further vague. This article portrays the influence of culture on mental health and emphases on the demand of cultural competence of the mental healthcare provider in cross-cultural clinical practice setting.

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Destination:
a real home for persons with special need

Monmi Das

A non-profit NGO, Destination is working for the individuals with mental health conditions, children with special needs. It also provides support and care to the homeless mentally ill persons. Destination believes in paving the way to raise awareness on mental health issues.

CHAPTER XIII

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Sohini Banerjee, Arabinda N Chowdhury

Globalisation and mass-migration led to a present era of cross-cultural mental health. India is characterised by cultural diversity. Culture determines the expression of distress. Assessment should be culturally appropriate. Treatment seeking patterns are also influenced by cultural differences. Adequate cultural awareness is a requisite for the health professionals. Providing fair and effective services is the aim of cultural justice.

Office-bearers
Preface

DR. HIMANTA BISWA SARMA, Ph. D. LLB
Minister, Assam

Message

It gives me immense pleasure to learn that the 24th National Conference of Indian Association for Social Psychiatry is going to be organized by Dept. of Psychiatry, Gauhati Medical College and Hospital from 17th to 19th November, 2017. I am also happy to know that a souvenir will also be published to commemorate the event.

It is learnt that for the first time a national conference of Psychiatry is being hosted in the North-East and theme of the conference is ‘Cultural Diversity and Mental Health’. I appreciate the endeavour.

It is hoped that the conference will provide a wonderful forum for all the participants to refresh their knowledge base, germinate ideas and to explore the latest innovations in the field of Social Psychiatry through fruitful deliberations that would result in better delivery of quality healthcare and patient care at large.

I would like to convey my very best wishes for an effective, successful and productive conference as well as the publication to be brought out on this occasion.

(HIMANTA BISWA SARMA)
Foreword

MESSAGE

It gives me immense pleasure to learn that the Department of Psychiatry, Gauhati Medical College and Hospital is organizing the 24th National Conference of Indian Association for Social Psychiatry from 17th to 19th November 2017. The theme of the conference “Cultural Diversity and Mental Health” is also very impressive for the society.

I am sure that the discussions and deliberations of the conference would immensely help the young Psychiatrists to learn the latest advances and researches in this field of Medical Education.

I wish a grand success of the Conference.

(Prof. Anup Kr. Barman)
Director of Medical Education, Assam.
Preamble

It’s my pleasure to welcome you all to the 24th National Conference of Indian Association for Social Psychiatry from 17th-19th November, 2017 at Hotel Radisson Blu, Guwahati.

This year the theme of the Conference “Cultural Diversity and Mental Health” is very appropriate as India is a culturally diverse society and people from wide range of backgrounds have different expectations and needs from mental health care delivery systems. Unfortunately health care in general is governed largely by the
dominant culture. Ignorance about cultural aspects play critical role in effective management of mental disorders. Mental health care professionals must be prepared to address each patient’s needs in culturally responsible ways.

There is a rapid expansion of knowledge and information and this tends to increase the knowledge gap. It is obvious that psychiatrists and mental health professionals who spend their time caring for patients find it difficult to keep up with the latest developments in the field. This conference will definitely help the delegates to catch up with the current understandings in the field.

I have no doubts that under the dynamic leadership of Dr. Phookun and Dr. Bora, the organizing team will spare no efforts to make this conference not only an excellent academic event but also provide great interactive platform for its members and their families.

I wish all success to NCIASP-2017

Dr. Rajiv Gupta
It gives me immense pleasure to welcome all the delegates for 24th National Conference of the Indian Association for Social Psychiatry, being organized by the Department of Psychiatry Gauhati Medical College and Hospital, Guwahati. The Conference is co-sponsored by World Psychiatric Association and World Association for Social Psychiatry.

The theme of the Conference “Cultural Diversity and Mental Health” is very apt and timely. Cultural diversity plays a significant role in various aspects of mental health and mental illness: symptom manifestation and interpretation, help seeking, coping and support, attitude to medications and psycho-social rehabilitation. This is for the first time that a National Conference of Indian Association for Social Psychiatry is being held at Guwahati, a cultural hub and gateway to Northeastern part of the country.

The scientific programme of the Conference is rich in content with award papers, lectures by eminent speakers, 10 symposia, workshops and more than 50 original papers. It is a matter of pride for IASP that mental health professionals practicing in various states of Northeast have contributed significantly to the scientific programme.

We hope that all of you will enjoy the Conference and find the programme useful!

Welcome to the Conference!

Mamta Sood
Secretary General, Indian Association for Social Psychiatry
Dear Esteemed members of IASP,

Greetings from the Organising Committee of 24th National Conference of Indian Association for Social Psychiatry..!

Welcome to “Awesome Assam”..!

We are indeed privileged and delighted to host the 24th National Conference of Indian Association for Social Psychiatry in Guwahati, the Gateway to the North East India.

We express our sincere thanks to the office bearers of Indian Association for Social Psychiatry for giving us this opportunity to host this conference, the first National Conference in Psychiatry in Assam and in fact in Northeast. The organising committee members have been giving their best for last few months to successfully conduct the conference. We take this opportunity to thank them all.
The scientific programme has been prepared with utmost care by the Scientific Committee of IASP to include all the domains in Social Psychiatry. The delegates will have opportunities to interact with the eminent mental health professionals across the country who will be speaking on the various issues related to the theme of the conference “Cultural Diversity and Mental Health”.

Without financial support, it would not have been possible to organise the event and we are very thankful to all the Pharmaceutical companies who have granted funds for the academic pursuit.

We shall leave no stone unturned to pamper you with our hospitality so that you carry some good memories from Assam while enriching your ideas and knowledge with the academic feast you are going to have.

We do believe that this conference will help us to understand our patients better and we shall be better equipped to minimise their sufferings and making their life better.

Jai Hind..!    Jai Aai Axom..!

Prof HR Phookun                Dr Utpal Bora
Organising Chairperson         Organising Secretary

NCIASP 2017
EDITORIAL

Cultural diversity, mental health, and social psychiatry

Shyamanta Das, Uddip Talukdar

“A long felt need of present day psychiatry is to understand the cultural influence on symptoms, management, and most importantly, on prevention of mental illnesses. This can be undertaken only by reporting and analysing the cases in that cultural rubrick. The journal aims to be the platform for discussions towards the same.”

About the Journal: Open Journal of Psychiatry & Allied Sciences, formerly Dysphrenia (OJPAS® 2010)

In 2010, when we started the journal, Dysphrenia, later rechristened to the Open Journal of Psychiatry & Allied Sciences (OJPAS®) (Das & Talukdar 2015), we incorporated the above paragraph in the ‘About the Journal’.

Niraj Ahuja (2011) proposed four revolutions of psychiatry. During the middle ages, mental illness was considered to be result of demonic possession, witchcraft, etc. Unfortunately, such believes persist in certain societies even now. Even then, following renaissance it was more or less accepted that mental illnesses are
diseases like other medical ones. So, this is considered the first revolution of psychiatry.

The evolution of psychoanalysis is considered the second revolution. Sigmund Freud gave a ‘structure’ to the specialty of psychiatry. After systematically arranging the different disorders, he tried for an aetiological classification. That, we trying now as well in this ‘biological’ era. Unfortunately, he did not have the investigative tools to substantiate symptomatology with brain pathology. Thus, various theories were postulated that at best can be understood at abstract level. Freud was liberal enough to accept changes. So much so that he himself changed some of his earlier theories. But, his followers had more or less ‘fixation’ that took the shape of concretisation of his ideas. As a result, psychiatry came to a halt for nearly half a century.

The dawn of pharmacotherapy gave a jolt to this static state of psychiatry which is the third revolution. Successful treatment of patients facilitated their movement from the asylums to the community. The phase of deinstitutionalisation started. Subsequent changes in the community in the form of social psychiatry is the fourth revolution of psychiatry. Of course, the community was not well equipped to deal with the patients by that time. So, came a stage of transinstitutionalisation as well.

Worth noting are the certain developments in contemporary psychiatry. On one hand, the attempt is to classify psychiatric disorders based on brain pathology (Das 2014). On the other hand, the attempt is to classify treatment according to mechanism instead of category (Talukdar 2014). In between lies the journey of psychiatry from phenomenology to neurocircuitry (Bardhan 2014).
Thus, we asked whether we are entering the phase of fifth revolution in psychiatry (Das et al 2015)!

Hereby, we try to first make a diagnosis. Then, deconstruct it to its domains, units, symptoms, and the like. Further endeavour is to locate the malfunctioning anatomy and physiology for the same. With knowledge of available therapeutic options and their mechanisms, choose the appropriate treatment that can reverse them (Stahl 2008).

We in medical science is used to treat diseases based on diagnoses. Once a diagnosis is made, there are guidelines to choose from the treatment. Against the backdrop of such traditional approaches, the ‘deconstruction’ one is comparatively new to us. Though, it seems more practical and more beneficial to the sufferers as well.

But, if we look into the psychosocial interventions, then we see that such an approach is followed there from earlier times already. These conversing rather than confronting pathways of both biological psychiatry and social psychiatry has the potential to go a long way as far as successful management of patients with psychiatric disorders are concerned. As this is based on hardcore brain pathology, not superfluous emotionality between them.

Thus, not only the disorder but the whole of the individual is managed in this way. And talking of the individual as whole, we cannot visualise them separately from their respective cultures. We cannot deny the fact that our understanding and treating of psychiatric disorders is heavily Northern American and Western Euro-centric.

Among the contributions of disorders from India to the world psychiatry, we can name two: dhat and jinjinia, also known as koro.
The jinjinia was first reported by Deepali Dutta and her colleagues from the state of Assam (Dutta et al 1982, Dutta 1983). Later on, there were more such reports from this part to the global platform (Roy et al 2011, Kumar et al 2014).

And it is the global context on which the earlier mentioned OJPAS® strives to form a consortium. With the already existing aim on cultural psychiatry, incorporated now is the promotion of behavioural science in low and middle income countries (LAMIC) (OJPAS® 2010). Cultural diversity is prominent among LAMIC. The only criteria that binds them together is the income (The World Bank 2017). Still, ‘LAMIC’ is an accepted concept (World Health Organization 2017).

Eighty per cent of the world population lives in LAMIC. Obviously the burden of mental illness is highest here (Kieling et al 2009). There is a huge gap between service users and service providers. In India, a LAMIC, lower middle to be specific, is an example (Kumar & Phookun 2016).

While on one hand the individuals with mental illness suffer because of this, on the other hand the clinicians have a tremendous exposure and experience in observing and managing a substantial number of patients. Even after considering the time constraints in such a busy clinical setting, when we look into the translation of such exposure and experience into scientific literature, the picture is not too bright.

What Kieling et al (2009) observed that among the psychiatric journals indexed in major international bibliographic databases like that of Web of Science and Medline (Clarivate Analytics 2017, U.S. National Library of Medicine 2016), only 4.1% such journals are from LAMIC. Rest all are from high income countries. Mari et al (2010) called it “the 5/95 gap”! Authors stated that difficulties arise
in achieving fair representation as a result for scientific production’s literature database. They highlighted the rarity of journals that have LAMIC focus as a major obstacle in disseminating research related to LAMIC.

Such a LAMIC focused journal from a LAMIC, i.e. India is what OJPAS® strives for. Taking inspiration from earlier such successful LAMIC endeavours, e.g. the Revista Brasileira de Psiquiatria and the Indian Journal of Psychiatry (Revista Brasileira de Psiquiatria 2017, Indian Journal of Psychiatry 2017), OJPAS® rolls on. OJPAS® is published by Academy Publisher (Academy Publisher 2014) on behalf of Academia Dysphrenia. Now, the Society for Mental Health in LAMIC (SoMHiL) joins hands (Global Psychiatry: A LAMIC Perspective 2017a).

Apart from the journal, SoMHiL also publishes life science books in order to promote behavioural science in LAMIC. This souvenir is the second such attempt. Earlier, in association with Bookbell (BOOBELL 2017), SoMHiL published a scientific update, titled “Autism spectrum disorder: present and future” (Global Psychiatry: A LAMIC Perspective 2017b). Five such books already to the credit of the team include: School mental health: mind the young minds, From genie to gene: genetics in behavioural sciences, Brain understanding of mental illness, Psychodermatoses, and Women and mental health (Global Psychiatry: A LAMIC Perspective 2017c).

Hopefully this new addition will enrich us more for which the credit goes to the contributing authors. Happy reading!

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Socio-cultural diversity vs. mental health

Putul Mahanta

Introduction

This theme of “Cultural diversity and mental health” uncovers the diverse effects of culture of a society on mental health, mental illness, and mental health services. The key is the understanding for developing mental health services that are more responsive to the cultural and social contexts of racial and ethnic minorities (National Institute of Mental Health 2001).

Cultural diversity and its impact on mental health has become an increasingly important issue in these modern era everywhere, where the interactions between cultures continue to grow exponentially.

“More often, culture bears on whether people even seek help in the first place, what types of help they seek, what types of coping styles and social supports they have, and how much stigma they attach to mental illness.” Culture also influences the meanings that people impart to their illness. Consumers of mental health services, whose
cultures vary both between and within groups, naturally carry this diversity directly to the service setting (NIMH 2001).

This article tries to present critical areas of how health and illness are perceived, coping styles, treatment-seeking patterns, impacts of history, racism, bias and stereotyping, gender, family, stigma and discrimination.

**Elements of cultural diversity and its effect on mental health**

Evidences are there to show that not only culture does play a significant role in terms of how society *understands* our health, but that different cultures *observe* this aspect differently and that these differences can play a key role in terms of how illness is managed (Kline & Huff 2007).

One aspect of difference across cultures relates to what the cause or nature of disease or illness is perceived to be. This can vary from notions of possession by spirits, yin/yang imbalances, the ‘evil eye’, black magic, or the breaking of taboos (Kline & Huff 2007, Ault & Brzuzy 2009). Views of health or illness causality range across the individual, the natural world and the social world, and every cultural group may see this differently (Ault & Brzuzy 2009, Helman 2007). This range of culturally informed understandings should provide roads for the physician to explore further, to come to a richer appreciation on the issues.

Culture modifies our *coping styles*, or the ways that we cope with everyday problems and to more extreme types of difficulty. Not only are there cultural variations in the types of stressors that people experience, but the assessment of stressors also varies, as do the choice of responses to stressors (Aldwin 2004).
The US Department of Health and Human Services (2001) noted such differences in coping styles when reporting that children in Thailand were two times more likely than children in the US to report reliance on covert coping methods, such as ‘not talking back’, as against overt methods such as ‘screaming’ and ‘running away’.

*Treatment-seeking* patterns vary across cultures and society to society. People from ethnic minorities are less likely to seek mental health treatment and also more likely to present in crisis compared with the majority community in Western countries (FECCA 2011). Some of these patterns can be examined in the context of how culture and the *history* of that culture modify therapeutic systems, and how interventions and therapists are viewed or trusted. Countries like Australia, where minority groups such as Aboriginal and Torres Strait Islander people have historically struggled with oppression and dispossession. Mental health professionals may be viewed as part of the problem (Bessarab & Crawford 2013).

The *historical context* can also play a significant role in terms of how mental health professionals perceive and work with their clients across cultures of different parts of the world. Many of the assumptions of what is normal and what is abnormal that are central to Western therapeutic approaches are based in Western, middle-class constructions that may not be valid when working across cultures (NCTSN 2005), adversely impacting on assessment, intervention, and evaluation-planning processes (Marsella 2011).

Racism is an especially potent influence within culture and its effect on mental health. Racism and discrimination are “umbrella terms referring to beliefs, attitudes, and practices that abuse individuals or groups because of phenotypic characteristics, e.g., skin color, facial features, etc. The four most recognized racial and ethnic minority
groups are themselves quite diverse. For instance, Asian Americans and Pacific Islanders include at least 43 separate subgroups who speak over 100 languages.

Racism is an especially potent influence within culture and its effect on mental health. Racism and discrimination are umbrella terms referring to beliefs, attitudes, and practices that abuse individuals or groups because of phenotypic characteristics, e.g. skin colour, facial features, etc. (USDHHS 2001). “The four most recognised racial and ethnic minority groups are themselves quite diverse. For instance, Asian Americans and Pacific Islanders include at least 43 separate subgroups who speak over 100 languages.”

Conclusions

Socio-cultural influences are not the only determinants of mental illness and patterns of mental health services for racial and ethnic minorities, but also they play some important roles. Mental disorders are prevalent across all populations, regardless of race, religion, sex, and ethnicity. The ethnic and racial minorities face a social and economic inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health. “Racism and discrimination are stressful events that adversely affect health and mental health. Stigma discourages major segments of the population, majority and minority alike, from seeking help. Attitudes toward mental illness held by minorities are as unfavourable, or even more unfavourable, than attitudes held by whites. Mistrust of mental health services is an important reason deterring minorities from seeking treatment. The cultures of ethnic and racial minorities alter the types of mental health services they use. Cultural misunderstandings or communication problems
between patients and clinicians may prevent minorities from using services and receiving appropriate care” (NIMH 2001).

While cultural differences provide a number of challenges to mental health policy and its implementations, they also provide a number of prospects to work in distinctive and effective ways towards positive mental health. Ethno-specific approaches to mental health that incorporate traditional and community-based systems can provide new avenues for working with culturally diverse populations.

Whatever the socio-cultural impact on mental health may be, the healthcare provides, society, and civil bodies must follow the rules, declarations, and international treaties related to mental health in letter and spirit, and should create a positive environment for all those needy people.

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Acute psychosis: Indian studies

Prosenjit Ghosh

Kapur and Pandurangi (1979) compared antecedent factors, phenomenology, treatment required, and prognosis among 30 cases of first episode acute psychosis with antecedent stress versus 30 cases of acute psychosis without stress. Stress was checked for in the last one month preceding the onset of psychosis. Cases were followed up for seven months. Hysterical behaviour, affective features, and psychomotor slowing were commoner in reactive psychosis, while tension/worry, impulsive behaviour, withdrawal and blunted affect were more common among the acute psychotics. The reactive psychotics had more life stressor prior to the illness as compared to the other group. There were more cases of affective psychosis in first-degree relatives of the reactive psychotics as compared to the acute psychotics. Reactive groups had premorbidly more disturbed and vulnerable personality. However, reactive psychotic patients had less disturbed ward behaviour and better social functioning than acute psychotic group without stress. They
recovered more completely in most cases. In follow-up, higher proportion of reactive psychotics turned out to be suffering from affective disorder and a higher proportion of acute psychotics without stress turned out to be schizophrenics. The authors have discussed the possibility that reactive psychosis and acute psychosis without stress may not be single, but multiple syndromes and that the differences observed in the two groups might be a characteristic of the Indian cultural context.

Singh and Sachdeva (1981) compared phenomenology, family history, and long term follow-up of 50 ICD-8 defined acute schizophrenia with that of 100 cases of manic-depressive psychosis and 100 cases of schizophrenia (diagnosed by Feighner’s criteria). Acute schizophrenic group had early onset and excellent response to hospital treatment (48% recovered) as compared to other groups. Schizoid premorbid personality was present in half of the study sample. Clinically, acute schizophrenics could be separated from process schizophrenia by absence of symptoms like feeling of passivity and flatness of affect, and on the other hand, from manic depressive psychosis by the absence of sad and euphoric mood, pessimistic attitude, guilt feeling, etc. The risk of family history of schizophrenia and manic-depressive psychosis was low in study sample when compared with controls. The authors concluded that their findings did not support the prevailing view of ICD-8 and ICD-9 that acute schizophrenic episode was a subtype of schizophrenia. They suggested that they were probably suffering from a third psychosis which on grounds of clinical features, response to treatment, family history, and course of illness tended to fall between the cases of true schizophrenia and manic-depressive psychosis.
Chavan and Kulhara (1988) followed up 22 patients diagnosed as having reactive psychosis for six months. Sixteen patients had clinical and social recovery. Three cases had relapsed and in three cases, the diagnosis of reactive psychosis was changed to either major depressive disorder or schizophrenia. The authors concluded that reactive psychosis has good outcome and stability of diagnosis over a short period of time.

A major multicentre study was conducted by the Indian Council of Medical Research (ICMR, 1989) at centres of Bikaner, Goa, Patiala, and Vellore, and included 323 cases of acute psychoses (age range 15-60 years). Overall prevalence rate was 8.7% of all cases of psychosis seen at four centres. Majority of cases was in the age range of 21-30 years with equal distribution of both sexes. In 54% of cases, the onset was abrupt within 48 hours. In 33%, it was between 48 hours and one week, and in only one per cent of cases between one and two weeks. At the initial contact, 35% were diagnosed as schizophrenia, 25% as manic-depressive psychosis, and remaining 40% as other non-organic psychosis according to ICD-9. The study also used its own ICMR descriptive categories for classification of cases, and also used PSE-CATEGO programme for classification. The most common presenting features were ideas of reference, delusions of persecution, irritability, agitation/excitement, overactivity, and inappropriate or bizarre behaviour. A large number of cases also had anxiety, depression. Psychological stress was seen in 26% of the cases and physiological stress in 30% of cases. Majority of patients (74%) had a normal premorbid personality. At one year follow-up, complete recovery without relapse was seen in 75% of cases. There was no relation of outcome to age, sex, premorbid personality, family history, presence or absence of stress. But favourable outcome was linked to abrupt mode of onset, and clinical features like perplexity, confusion, and bizarre behaviour.
Janakiramaiah et al (1992) conducted a study to compare the demographic characteristic and hospital course of schizophrenic patients with an illness of less than one month (comparable to acute and transient psychosis in ICD-10) with those schizophrenic who had longer duration of illness at the time of their first admission to the National Institute of Mental Health and Neurosciences, Bangalore, India. The study was retrospective in design. The authors reported that the patients with less than one month duration of illness stayed in the hospital for less number of days and were in a better condition at the time of discharge. The authors supported the idea of separating the patients with less than one month duration of psychoses from schizophrenia.

In the Chandigarh Acute Psychosis Study (CAPS) in Northern India, a cohort of 91 cases of acute psychotic illness were assessed for symptoms, diagnosis, and course ratings at multiple intervals over a 12-month period. The CAPS represents one of the 11 centres that participated in the WHO study on acute psychosis (Cooper et al., 1990). Cases were drawn from a rural and urban clinic, permitting comparison. All patients at intake were assessed by PSE and SCAAPS (developed by WHO for their study). Symptom ratings were made at eight time points during ten weeks after intake (at three days, and at one, two, three, four, six, eight, and ten weeks). The SCAAPS was administered in two compressive assessments at three and 12-month follow-up. Non-affective (mainly schizophrenic) patients were the predominant group (51%), followed by manic (26%) and depressive (19%) patients. Prognosis was good with 70% of patients having full remission. Majority (71%) of patients showed no impairment in social functioning at 12-month follow-up. Mean age of non-affective cases were 26 years, that of manic cases, 29 years and of depressive, 33 years. Course and outcome were similar in rural and urban areas (Varma et al., 1996).
Susser et al (1998) reported 12 years follow-up data for the Chandigarh sample in WHO-DOSMED study. Index diagnosis was based on data collected at intake and a two-year follow-up. In this study, criteria for NARP were refined (now called “acute brief psychoses”) as compared to the earlier definition (Susser & Wanderling, 1994; Susser ., 1996). Early relapse (up to two years after onset) was no longer allowed; otherwise, a diagnosis of acute relapsing psychosis was assigned. At 12-year follow-up, 17 of the initial 20 patients with acute brief psychosis were available and were compared to 36 patients with other forms of remitting psychoses. At 12-year follow-up, only one of 17 patients (six per cent) with acute brief psychosis was still considered ill, in contrast to 50% with other remitting psychoses. Re-diagnosis of the index episode according to ICD-10 resulted in 11 cases of schizophrenia, three of other acute and transient psychotic disorder (ATPD), two with acute schizophrenia-like psychotic disorder, and one with non-organic psychotic disorder.

Another study (Collins et al., 1996) explored biological and psychosocial contributions to incidence of acute brief psychoses in three developing countries. The study used data from five-year follow-up investigations in Ibadan, Nigeria, and Agra, India (patients recruited in International Pilot Study of Schizophrenia) and in rural Chandigarh (Patients from DOSMED). Results showed an association between fever and acute brief psychosis in all three sites, and also association between psychosocial stressors like job distress and acute psychosis.

Collin et al (1999), in an analysis of a special subsample of DOSMED cohort from rural and urban Chandigarh found that in the NARP sample, eight out of 17 patients had antecedent fever during the 12 weeks before onset, while among control (acute or
sub-acute psychoses other than NARP) five of 40 patients had antecedent fever, yielding an odds ratio of 6.2.

Das et al (1999) conducted a family study on 40 probands with ATPD and 40 patients with ICD-10 schizophrenia in Chandigarh, India. The main result of this study was that first-degree relatives (FDRs) of ATPD probands had a higher prevalence of ATPD than those of schizophrenic probands. FDRs of schizophrenic probands had significantly higher prevalence of schizophrenia than those of ATPD probands. However, ATPD subtypes with schizophrenic symptoms had more family history of schizophrenia than rest of ATPD subtypes. They concluded that ATPD had a differential pattern of risk of illness when compared to schizophrenia and the subtypes subsumed under ICD-10 ATPD may be genetically heterogeneous.

Gupta and Bhardwaj (2000) assessed 62 out of 68 patients of acute psychoses who were initially recruited at Bikaner centre in 1982 for Indian Council of Medical Research study of phenomenology and natural history of acute psychoses (ICMR, 1989), after completion of ten years. Schedule for Clinical Assessment of Acute Psychotic States (SCAAPS) and Present State Examination (PSE) were used for the assessment. The authors found that more than 56% (35 patients) of acute brief episode of psychoses did not have any episode of psychoses during the course of follow-up after the initial illness. The factors associated with good prognoses include: being young and unmarried, abrupt onset within 48 hours, belonging to Hindu religion, and having a clinical presentation of excitement as opposed to withdrawal. No other socio-demographic or clinical variable could distinguish this good prognosis group from the rest of the patients. This study justifies the inclusion of acute non-organic psychoses as a separate group in the classificatory system.
In a major study, Sajith et al (2002) assessed consecutive patients, meeting ICD-10 criteria for ATPD, polymorphic subtype without symptoms of schizophrenia in a hospital in Pondicherry, India. The criterion for full remission within three-months was operationalised by the authors as achieving at least 80% of the premorbid global assessment of functioning (GAF) score. Fifty-two patients out of initial 58 met this criterion. Patients were reassessed at one month, three months, and six months, and at the end of three years. Revision of diagnosis was attempted at each stage of assessment using the ICD-10 criteria. Three-year follow-up data available for 45 out of 52 patients showed: there was female preponderance in sample (71.1%), mean age was 26.9 years without any gender difference, onset was abrupt for 66.7% and acute for 33.3% of patients, the duration of index episode was less than one month in 53.3% patients and between one to three months in 46.7%, and stress within two weeks prior to the onset of psychosis was present in 68.9% of patients. At the end of three years, 73.3% of patients retained their index diagnosis of acute polymorphic psychotic disorder, 22.2% were re-diagnosed as bipolar affective disorder, and 4.4% were re-diagnosed as unspecified non-organic psychosis. Patients retaining the diagnosis of acute polymorphic psychotic disorder had a significantly better outcome in terms of GAF score.

Chakraborty et al (2005) followed up 40 ATPD patients over six months, and found that diagnosis was changed in 21 patients and the commonest change was to bipolar disorder (n=12).

Thangadurai et al (2006) followed up a sample of ATPD patients over a mean period of 13.2 months and found a favorable outcome, with 52.9% patients remaining symptom free. Good outcome was attributed to prompt treatment with antipsychotics. Diagnosis had to
be changed to affective disorders in 9.2% and schizophrenia in 26.4%, and 11.5% presented with recurrent episodes of ATPD.

Emmanual and Ram (1983) in a controlled study assessed acute psychosis and found: mean age of onset of 32.5 years, male predominance amongst acute psychotic patients, more cases from rural background, well-adjusted premorbid personality, no family history, associated stressors in more than half of patients (52.5%). Most common presentation was hallucination, excitement, paranoid delusion, and affective symptoms.

Verma and Sharma (1991) studied the course and outcome of cycloid psychosis and found: mean age of onset of 29.52 years and a female predominance. Course was episodic in cycloid psychosis and there was a favourable outcome.

Mishra and Ram (1996), in a controlled study, assessed short-term outcome of acute and transient psychoses and found a rapid recovery and better outcome of ATPD group in comparison to controls.

Deb and Ram (2001) studied the phenomenology of ICD-10 defined acute and psychotic disorders and found: mean duration of an episode was 16.08 days, half of the patients had past history suggestive of ATPD, 32.1% had family history of psychiatric illness, 10.71% had family history of ATPD, majority (96.4%) had well-adjusted premorbid personality disorder, 50% had associated psychological stress and 17.9% had physiological stress.

Chakraborty and Paul (2001) found no significant difference in frequency of total life events, life event in the preceding six months between the acute and transient psychosis group and the control groups.
Nongpiur and Sinha (2006) in a study on “Diagnostic stability in patients with multiple admissions for psychosis” found a stability of acute conditions like ATPD; schizophréneiform disorder to be low with 50% of them changing the diagnosis at the second admission itself.

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Mobile culture and mental health

Pinaki Chakravarty

The definition health encompasses the wellbeing of physical, mental, and social fitness. Mental health is apparently not visible unlike physical health. The mental health is influenced by many factors. As the person grows, his mental health matures with increasing age. His behaviour with self and others reflects the mental health status.

The culture of any region have its impact on health, be it physical or mental. The diversity may be appreciated if people from different backgrounds are observed in their day-to-day living. India is a country with “unity in diversity”.

Even within a region, many cultural differences do exist. The growth and development of a person living in a particular society is naturally moulded to the norms and regulations of that particular place. The cultural diversity is inherent and natural which affects the health.

Of late, a new culture of using Android or mobile phones is affecting all the cultures globally. This is a serious concern and people of all ages are hooked to it. The mobile culture is affecting
the mental health the most. Unfortunately, it is doing more harm and causing various mental disorders, which need to be addressed by the mental healthcare professionals on a war footing. Many new entities are being included due to mobile culture problems. This addiction to smart phones is difficult to treat. The increased access to Internet and keeping busy with the phone is a concern in every house. The family members are not communicating with each other and everyone is busy with the phones. The value of friendship and relatives are now taken over by ‘virtual’ friends. Many of the virtual friends are chatting useless topics and are not really concerned with the real world. Watching adult contents and pornography is harming the youth and old alike. Precious productive time of life is wasted with the phones. Playing online games have shifted the children from playing grounds to mobile screens. Social sites are causing unnecessary confusion and stress. Online marketing compels one to buy useless, poor quality products, wasting money and time.

The Internet is full of information. Free access to the information is creating confusion amongst the users. Most of the information are not authentic and are not verified. The contents are imparting little knowledge, which is dangerous to the users. The person is over flooded with information through the Internet and most of these is not useful. The communication have improved but camaraderie have gone down. People are getting too many calls, but are not talking to the person sitting with him. Mobile phone culture have intruded to our lives to the extent that the first thing we see in the morning are the mobile screens. Sleep is disturbed, as at night too, mobiles were the last thing we watched. Use of mobiles have caused many accidents too, but still the menace of phones are not realised.

The students are using Google for almost everything. The creative mind is being lost gradually. Everyone accesses Google, as it is easy
and fast. However, there are many drawbacks. The plagiarism and copy pasting have increased, as the contents are easy to access without much hard work. The books are not read these days. The students are comfortable with e-books. The handwriting is not important. How fast one can type matters!

The cybercrime is increasing. People are having new problems in maintaining relationships. Faithfulness to the partner is doubted. The new gadget have started monitoring our daily activities and is jeopardising our privacy. The morphed photos and virtual images, which are obscene, are damaging the social values and are threat to the self-security. The inbuilt apps are misused. The hackers are doing no good. Hackers are looting hard-earned money from the banks bankrupting the victim. The young children are also fond of mobile phones as they can watch cartoons and play games.

With new mobile towers in everyplace in our country, the crop yield have reduced. In many places, the coconut and betel nut are not bearing the fruit, but only outer shell grow. The day is not far from now that I am afraid even to imagine about a time in future when babies will be born with the empty skull and no brain matter inside. All the brain functions by that time would be taken over by the robots and mobiles may be.

The mobile phones are needed to communicate, but not at the cost of happiness and pleasures of life. The basic and elementary things in our life can be attained without mobile phones and modern gadgets. People are happier, healthier, wiser, richer, caring, emotional, and at peace without mobiles. Being human being, we do not have control of our lives anymore these days. Our lives are disturbed by the inventions we made. Stresses in our present lifestyle have started taking its toll. ‘Selfie’ have already been recognised as a
psychiatric problem. There will be many more coming. Sooner these problems are addressed in a scientific way, better it will be for the world.

The psychiatrists have an important role to play. During the Blue Whale game problem, the psychiatrists played a vital role. Society is already full of tension. Mobile phones and electronic media are giving rise to new issues, and we all must be ready to take up the call and act. We must march on with the quiet certitude that what has to be done will be done. Minds, like parachutes, only function when open. The time to trust is not just when all is calm. The most important time to trust is through the raging storm. Facts do not cease to exist because they are ignored.
CHAPTER IV

Awareness towards cervical cancer: impact on mental health

Usha Sharma, Bidula Sarmah

Introduction

The term “cancer” is always a worrisome word to anyone. It brings a challenge in terms of money, manpower, and mental status of not only to the sufferers, but also to their families, friends, and the surroundings. For most of the people, cancer is a very dreaded, non-curtable, and pathetic disease that, if one has cancer, it is impossible to be cured and live a normal life afterwards. Apart from the burden of financial factors, there is always a fear of losing them at any moment. Having cancer, one get suffered not only by physical pain, also by mental agony and emotional disturbance. People are ignorant many a time that many cancers are preventable and curable, if diagnosed at the earliest. Cancer of uterine cervix can be prevented by specific vaccination. BCG vaccination is used to control the urinary bladder cancer. There are regular cancer screening programmes available; but, these programmes are still out of reach
to the population who are at risk. Knowledge of the factors associated with cancer and awareness to avoid those risks will reduce the burden of cancer incidence and cancer-related death. One of the cancers that can be prevented is cervical cancer, which occurs due to a persistence of human papilloma viral (HPV) infection. Only due to lack of knowledge of this cancer, it is still second most among the top ten cancers globally (IARC 2008).

The incidence of cervical cancer is decreasing in the developed countries. But, HPV-related cervical diseases including cervical intraepithelial neoplasia (CIN) and cervical cancer continue to be a major health problem in developing countries, including India. India has a population of 366.58 million women, aged 15 years and older who are at risk of developing cervical cancer. In India, cervical cancer ranks the first most frequent cancer in women (Summary Report Update 2010). The disproportionately high burden of cervical cancer in developing countries is largely due to a lack of screening that allows detection of precancerous and early stage cervical cancer (IARC 2008).

Coming to the scenario of cervical cancer in Assam, it ranks first among top ten sites with prevalence being 15% (Kataki & Sharma 2012). Cervical cancer ranks second out of top ten common cancers in Kamrup Urban district (NCRP-ICMR 2008). Factors like early sexual intercourse, multiple sexual partners, and a male partner with previous multiple partnership have already been established as determinants for cervical cancer (Sarma et al 2013). Other associated factors include oral contraceptive use, cigarette smoking, parity, family history, poor socioeconomic state, associated genital tract infection, and lack of circumcision in the male partner (Sarma et al 2013). The illiteracy, high parity, and early age of marriage are some other determinants of HPV infection (Schiffman et al 2007).
Sexually transmitted HPV infection is the most important risk factor for CIN and invasive cervical cancer (Ferlay et al 2010). Infection with high risk HPV has been strongly associated with progression to invasive cervical carcinoma (Singhal et al 2008). Usually, HPV infections are asymptomatic and low risk HPV cleared within two years; persistent genital HPV infection can lead to clinical disease including anogenital warts, CIN, cervical carcinoma, and other anogenital cancers. Cervical cancer is the first kind of cancer that can be prevented through vaccination, as this cancer has an infective aetiology. As the viral particle enters the cervical epithelium through sexual route, so vaccination against high risk HPV infection prior to the start of the sexual activity decreases the risk of cervical carcinogenesis.

In spite of having an effective vaccine against cervical cancer, it is the second most common cancer among women worldwide, with an estimated 529,409 new cases and 274,883 deaths in 2008 (Singhal et al 2008). If one can avoid the exposure to the risk factors that lead to cervical carcinogenesis, one must be vaccinated against the high risk strains of HPV. For this, knowledge of HPV and its awareness is very necessary at grass roots level.

Acquisition of HPV occurs through sexual contact. Most infections clear spontaneously, generally within one to two years. Persistent infections, which can last for ten or more years, lead to high grade cervical lesions and eventually invasive cervical cancer, if no intervention has been undertaken. Though there may be spontaneous remission of low grade cervical lesions, but can also progress to higher grade lesions (pre-cancer) and cancer (Ferlay et al 2010). Basic knowledge regarding cervical cancer can change a woman’s life to a more meaningful one. A woman must know the following:
Cervical cancer is an infectious disease caused by a sexually transmitted HPV infection. There are more than 100 subtypes of HPV, out of which 15 subtypes are categorised as high risk due to its affinity for persistence in the cervical epithelium. Persistent high risk-HPV infection can transform an infected cervical cell to a dysplastic change. This dysplastic cell can progress to neoplastic transformation. The process of neoplastic transformation takes more than ten to 30 years. Routine Pap smear testing can detect the abnormal cells and treated at pre-cancerous state only. Screening of HPV and its genotype helps to distinguish exposure of high risk to low risk HPV subtypes; so that, it helps to predict the clinical behaviour of the HPV infection and probability of carcinogenesis in future.

**Impact of HPV vaccination on cervical cancer**

Cervical cancer is the first kind of cancer that can be prevented through vaccination. Two vaccines licensed globally are available in India; a quadri-valent vaccine (Gardasil™ marketed by Merck) and a bi-valent vaccine (Cervarix™ marketed by Glaxo Smith Kline) (Singhal et al 2008).

Gardasil™ is a mixture of L1 proteins of HPV serotypes 16, 18, 6, and 11 with aluminium-containing adjuvant. This vaccine confers protection against both cervical cancer and genital warts (Singhal et al 2008). Cervarix™ is a mixture of L1 proteins of HPV serotypes 16 and 18 with AS04 as an adjuvant. There are three doses of this vaccine that can be given to women at zero, one, and six months.

A study by Harper et al (2004) showed HPV vaccination helps to have 90% efficacy against type 16/18-related CIN grade 2 and grade 3, and adenocarcinoma in situ (included women who were at baseline negative for HPV DNA of vaccine type virus and who
received at least one dose of the vaccine). Follow-up studies in a subset of participants over four to five years showed no evidence of waning immunity (Harper et al 2004). This vaccine confers protection only against cervical cancer (Harper et al 2004).

**Impact of HPV vaccination on mental health**

Primary prevention of cervical cancer is thus possible by early immunisation of female adolescents with a vaccine which is effective against a few significant HPV types, mainly type 16 and 18. The use of the vaccine can help prevent from 44% of intraepithelial neoplasia and 71% of invasive cervical cancers (Onuki et al 2009).

Female illiteracy may be considered as one of the important social factors for HPV infection. Many Indian people in the society feel that girl child is burden and think that educating her is waste; after all, she is going to another house after marriage. Some think that girl child will be safe within the four walls of house due to many anti-social activities against woman that takes place. Some, due to the old believes, custom, and tradition, do not educate the girls. Sex education and awareness about HPV infections are another vital issue for young girls and boys, who are not yet exposed to sexual activity. Primary prevention of HPV infections and cervical cancer with vaccination is most effective in teenage girls. If each member of the society is aware of infectious origin of cervical cancer and preventive measure, they can approach for HPV vaccination at the right time. Primary prevention of HPV infections and cervical cancer with vaccination is most effective in teenage girls.

Secondary prevention of cervical cancer is also possible through periodic (annual) screening of sexually active females by Pap smear; a cotton swab is used to take exfoliates of cervical cells for observation under the microscope. It can diagnose early forms such
as in-situ malignancy which can thus be treated before changing into invasive cancer. Pap smear screening at regular interval detects the early morphological change at pre-cancer stage, and thereby reducing the incidence of invasive cervical cancer.

The currently available vaccines can protect about 70-80% of cancers caused by HPV-16 and 18; hence, screening will have to continue, as other high risk HPV cannot be protected by existing vaccine. The women should be taught and sensitised for HPV vaccination and cervical cancer screening programme. Health education on the level of knowledge regarding cervical cancer and its determinants has a positive attitude of women to avail the HPV testing and/or cervical cytology screening methods.

Knowledge and health education of cervical cancer among the population helps woman rather young girls to take necessary steps like vaccination that prevent high risk HPV infection and lower down the possibility of cervical cancer development in later life. Similarly, availing the routine Pap smear screening by sexually active woman is necessary step to prevent the chance of cancer development. Knowledge and awareness always helps to cut down the unnecessary mental anxiety and agony of fear of cancer-related morbidity and mortality.

Hence, it is the need of the hour for health professionals as well as policy makers to identify a fraction of these vulnerable women, who might be at an elevated risk of developing cervical cancer, later in their lives. Moreover, regular Pap tests in combination with HPV testing, wherever possible may be recommended to successfully manage HPV infection and reduce the HPV associated disease burden among these groups of women. Continued monitoring of HPV infection through follow-up study will be an important strategy
for evaluating early population impact of current and future HPV vaccines, and may be useful for guiding policy and public health practice.

Conclusion

Cancer cervix is preventable, and one of the important aspects in prevention is detection of the premalignant lesions by screening. The awareness about cervical cancer, its risk factors, and the methods of prevention is limited among women. The knowledge gap towards cervical cancer is due to lack of continuous health education at grass roots level which has poor impact on cervical cancer control. Also, there is no uniformity in cervical cancer screening programme in the country. Effective information, education and communication strategies are required to improve the level of awareness of public, and attainment of positive attitude and mental health.

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Dissociative disorder: a cross-cultural journey

Krishan Kumar, Vikas

Introduction

Culture is beset by confusion because of a lack of concise, universally acceptable definition, but considered to play a vital role in psychiatry. Culture can be conceptualised as a totality, composed of a complex system of symbols possessing subjective dimensions such as values, feelings, and ideals and objective dimensions including beliefs, traditions, and behavioural prescriptions, articulated into laws and rituals. This sole power of culture is to connect the objective world to the subjective world of the personal quality of an individual in which he/she acts as expressor, mediator, and moderator of psychological processes and ultimately, emotional disorders (Trujillo, 2001). Culture distinctively influences mental health of people living in a given society. At every stage of mental illness, course and outcome of mental health problems are influenced by cultural issues. It is pertinent to understand the cultural milieu of patient, as it can help to understand the patient and his psyche which influence the disease and healing process.
It is evident that no specific culture confers absolute immunity against psychological vicissitudes. The forms of psychiatric disorders are identical in all cultures, though the content of symptoms differs. It has indispensable impact on dissociative disorder, which is considered to be influenced by socio-cultural values, beliefs, traditions, and obligations in acquisition as well as treatment. Across all over the world, it is believed that dissociative experiences take place due to stress, socio-religious belief system, and finally, cultural factors (Kirmayer & Santhanam 2001). It is often assumed that dissociation across these different settings involves the same underlying psycho-physiological mechanisms. However, there is uncertainty in current literature about both the mechanisms and functions of dissociation which varied across cultures. For the most part, the anthropological discussions of dissociative phenomena in cultural context (e.g. trance and healing, possession states) have remained separate from the clinical and experimental literature on dissociation.

Most psychiatric approaches to dissociation do not explore the social meaning of dissociative experience and how these meaning influences its adaptive or maladaptive consequences, which are based on individual archetype, class, society, and culture. Most anthropological approaches to dissociation focus on the discursive functions of dissociation and do not consider the emotional and socio-cultural facet of dissociative experiences.

**Socio-cultural meaning of dissociation**

A feature of dissociative experience is that a large proportion of dissociative phenomena around the world is considered to be completely normal and non-pathological (Bourguignon, 1973). Normal dissociation includes out-of-body experiences, automatisms
in daily life, and repetitive and cognitive absorptions; all of these experiences have some roots in culture which they belong (Butler, 2006; Cardeña, 1994; Steinberg, 1995). Around the world, it is believed that the religious content of dissociative phenomena especially trance and possession are considered normal, and these states do not expose any agony and are often experienced as beneficial and adaptive (Castillo, 1997; Golub, 1995; Goodman, 1988; Lambek, 1981; Lewis-Fernández, 1994).

Therefore, if one experiences dissociative features (especially with religious context), it is decisive to determine the extent to which it truly represents a pathological experience or not. The possible explanation in this respect, whether dissociative experiences are normal or pathological depend on the extent to which the state is associated with distress and impairment, and also the degree to which it is atypical or non-normative for the cultural group. This implies that the assessment and clinical judgement must take into account features of the socio-cultural context, particularly the influence of the ascribed explanatory models for the experience, which include its interpretation, perceived causation, expected consequences, and relationship to established practices, often of a religious or supernatural nature (Kleinman 1980; Lewis-Fernández, 1994; Martínez-Taboas, 1991, 1999, 2005).

In some cultures, dissociative experiences occurring during the practice of spirit mediumship do not usually impair the medium. On the contrary, such experiences can be interpreted as “a call to heal” (Krippner, 1989) or as the possession of a precious gift, and are culturally normative. Depending on the phenomenology, socio-cultural context, and interpretation of the experience, possession states can be completely normal expressions of religious commitment which can be distressing but transient symptoms of
interpersonal or social conflict, or pathological afflictions causing intense fear, anguish, and impairment (Freed & Freed, 1990; Gaw, Ding, Levine, & Gaw, 1998; Goodman, 1988; Lewis-Fernández, 1992). In order to understand to what extent specific dissociative experiences are normal or pathological, it is crucial to assess their social construction and the plurality of cultural meanings associated with them (Martínez-Taboas, 2005; Somer, 2006).

Similarly, dissociation in ritual contexts indicates how readily dissociation is shaped and controlled by cultural expectations and ongoing social interaction. This cultural building of dissociative experience is not so much a matter of fixed scripts for dissociative behaviour, but it is an interactional process in which dissociative behaviour emerges in response to, and as an expression of, powerful and contested relationships. Therefore, one can interpret dissociative experiences that dissociation model depends on the cultural underpinnings of an individual. For example, multiple personality disorder appears to be primarily a Western phenomenon (Bourguignon, 1989). In many non-Western cultures, when individuals experience self-directed voices or agents within themselves, these are generally believed to be spirits, ancestors, and other culturally determined historical or communal agents rather than episodes or strands of personal history. From a cross-national perspective, possession is a common way of experiencing and describing dissociative phenomena, and multiple personality disorder is a culture-specific way of describing possession, based on the central role of the individual in cultural context.

**Culture-related syndrome and dissociative disorders**

Psychopathology of an individual in psychiatric disorder solely depends on culture. However, some psychiatric syndromes are
restricted to certain specific cultures. These disorders are called culture-bound syndrome. Culture-bound syndrome is a mixture of psychiatric and somatic symptoms which are pertinent or specific to a particular culture. Many culture-related syndromes might be classified as acute dissociative disorders. DSM-IV groups together amok, latah, bebuinun, piblokoq, phiï pob, vim buza, and ataques de nervios as dissociative disorders not otherwise specified (DDNOS). Here, this nosological generosity is problematic, because these syndromes have little in common except for a tendency to be amnesic for the illness episode. This claim of amnesia may or may not represent dissociation. Most of these terms are folk illnesses or attributions that cut across many DSM-IV categories. In addition, latah is not an illness, and some, like piblokoq, are historical curiosities whose prevalence and pathological significance was never adequately established. To comprise these disorders under the dissociative disorders overlook the effects of social influence and expectation on symptomatic behaviour, independent of any processes of dissociation.

Most of the culture-related syndromes do not fit neatly within one broad category of the DSM. For example, ataques de nervios is a culturally shaped syndrome that cuts across conventional psychiatric distinctions among anxiety and affective and dissociative disorders, and requires rethinking of the relationship between these disorders. The most common symptoms of ataques are bouts of uncontrollable shouting and of crying (Guarnaccia, 1993). Dissociative symptoms involving loss or alteration of consciousness and amnesia may go with ataques (Lewis-Fernandez, 1992).

It is part of the cultural sense of ataques de nervios, that they are aggravated by an upsetting event; as a consequence, the salience and severity of the precipitant must be emphasised by the sufferer to
justify or make sense of an episode. This does not mean that ataques is simply a stress response syndrome. Whereas ataques may occur in the context of individual psychopathology, marital or social conflict, it also serves itself as a legitimating explanation for many other forms of distress.

**Dissociative disorders across different cultures**

Meanings and attributions are integral parts rather than epiphenomenal aspects of dissociative presentations, and help to shape the local phenomenology of dissociation around the world. Dissociative disorders have different representations across cultures. Researches show that the dissociative disorders exhibit themselves either as a high prevalent disorder in a particular culture or as specific cluster of symptoms that are unique to that particular culture. For example, in Nigeria and India, common symptoms are feeling of heat, burning sensation of head and feet, peppery and crawling sensations, and these symptoms are very rarely found in Western countries (Escobar, 2004). Alexander, Joseph and Das (1997) found that in India, most patients of dissociation presented symptom like “brief dissociative stupor” along with anxiety and panic symptoms, which is again different from what is found in West. Similarly, research showed that dissociative disorders are rare in South Africa among blacks and it was not found to be related to traumatic experiences like sexual abuse (Gangdev & Matjane, 1996). One more study revealed prevalence of dissociative disorders above ten per cent in psychiatric inpatients and outpatients in Istanbul, Turkey and prevalence was found to be lower in Netherland, Germany, and Switzerland (Gast, Rodewald, Nickel, & Emrich 2001; Modestain, Ebner, Junghan & Erni, 1996; Friedl, Draijer & Jonge, 2000).
Among dissociative disorders, dissociative identity disorder (DID) is more frequent than other subtypes. Research on DID showed that more than 60% of cases are reported from north America and are prevalent as a culture-bound syndrome (Golub, 1995). Though DID is rare in Britain, Sweden, Russia, India, and South East Asia. Also in US, DID is rare among Latinos and Asian Americans. The importance of culture was again found in one study done in Canada on DID patients and it was seen that 20% of DID patients were having alternate personalities that belonged to different race in Canada. Perhaps reflecting the higher levels of ethnic integration reached in that country (Escobar, 2004). The diagnosis of DID is not taken seriously, e.g. in Northern Ireland, because the mental health professionals get trained under different British societies, and British psychiatry is relatively conservative and sceptical regarding concept of DID. A study was conducted and results revealed that 65% among complex cases were positive for at least one dissociative disorder in Northern Ireland (Dorahy, McCusker, Loewenstein, Colbert & Mulholland, 2006).

There are other dissociative syndromes that are confined to culture completely. Such culture-bound syndromes are rarely considered as pathological in many cultures. Latah is one, found in Indonesia, characterised by exaggerated startle motor response, followed by hyper-suggestibility and mimic cry accompanied by obscene expressions. Pibloktoq is the other syndrome found in native people of the Arctic, characterised by alteration of consciousness and erratic behaviour. Studies show that many of these conditions are regarded as harmless, as Latah is one example where it is considered as undisruptive and even entertaining. Similarly, Amok is found in Malaysia which is characterised by period of brooding, followed by an outburst of violent, aggressive, and homicidal behaviour that is directed at people and objects around. Zar is a condition found in
Ethiopia, Egypt, Iran, and in Middle East. This, considered as a spirit possession, which is characterised by dissociative episode of laughing, shouting, singing, etc. Affected individuals may develop long term relationship with spirit and at the same time, this condition is not considered as pathological.

**Indian context**

Conversion disorders and dissociative disorders present different pictures in India. In one study, the prevalence of hysteria in rural areas was 1.9 out of 1000 and in urban population, prevalence was 3.1 out of 1000 (Lal, Biswas & Chaudhery, 1991). Nandi, Banerjee, Nandi & Nandi (1992) did a survey of two villages over ten and 15 years, and it was found that the incidence of depression increased and of hysteria decreased from 16.9 out of 1000 to 4.6 out of 1000 in one village and in other village, the decrease was from 32.3 out of 1000 to 2.05 out of 1000. This decrease was attributed to the improved socioeconomic status of women. The common disorders in India have been conversion disorders and atypical dissociative disorders (Saxena & Prasad, 1989; Deka, Chaudhury, Bora, & Kalita 2007). The prevalence of dissociative disorders in India was found to be 2.3% in the sample of 2651 adult psychiatric patients (Saxena & Prasad, 1989). Researchers found that around 90% of patients with the diagnosis of atypical dissociative disorder. Interestingly, DIDs have been very infrequent in India (Verma, Bouri & Wig, 1981).

Recently, a study was conducted by Chaturvedi, Desai and Shaligram (2006) aimed to see the patterns and presentations of dissociative disorders in India. The sample population included the patients from year 1999-2006, both inpatient and outpatient groups in NIMHANS Bangalore who were diagnosed as having dissociative disorders. Out
of 893 patients, 26% of total sample were male and 74% were female. Results showed that among outpatients, 4.1% were
diagnosed as dissociative amnesia, 1.4% with dissociative fugue,
6.6% with dissociative stupor, 43.3% with dissociative motor
disorder, dissociative convulsions in 23%, dissociative anaesthesia in
0.8%, trance and possession in 11.5%, mixed dissociative disorder
(4.1%), and other dissociative disorders (2.4%). And among
inpatients, majority were diagnosed as dissociative motor disorders
(37.7%), dissociative convulsions (27.8%), trance and possession
(5.3%), and dissociative stupor (5.3%). Unspecified dissociative
disorder amounted 6.3%.

Puerto Rico communities in the US

Most of the research on dissociative phenomena reported with Latin
American populations has been conducted in Puerto Rico or among
Puerto Rican communities in the US. In an Island-wide household
probability study of youth aged 11–17 (N=891), Martínez-Taboas,
Canino, Wang, García, & Bravo (2006) assessed the prevalence of
pathological dissociative symptoms and their relationship to
different types of victimisation experience. As expected, most
adolescents in Puerto Rico (53%) did not indicate any symptoms of
pathological dissociation. The prevalence of pathological
dissociation was 4.9%. Confirming an association between
pathological dissociation and abusive experience, nearly all (98%)
participants indicated a history of some type of victimisation.

The prevalence of ataque de nervios has been studied extensively in
this community. The prevalence of ataque de nervios was found to
be 10.4% with no relationship to alcohol or drugs (Guarnaccia,
Canino, Rubio-Stipec & Bravo, 1993). Ataque was more prevalent in
women over 45, without a high school education, who were
previously married (separated, widowed, and divorced), and out of the labor force or unemployed. A community-based, representative study of children and adolescents aged four to 17 (N=1,886) found a prevalence of ataque of 8.9% (Guarnaccia, Martínez, Ramírez, & Canino, 2005). In that study, ataque was associated with female gender, age ≥15, and low income. Both studies found that ataque de nervios is mixed from a psychiatric perspective, showing a relationship with several psychiatric diagnoses, including anxiety and depressive disorders, but neither study assessed directly for the presence of dissociative pathology. Consistent with the finding of Puerto Rican, there was an association between ataque frequency and higher dissociative pathology, and should be directly assessed in community.

**Turkey**

A community survey of the female population of Sivas City was conducted in 500 homes (Sar, Akyuz & Dogan, 2007). This study provided more robust lifetime prevalence rates of DSM-IV dissociative disorders. The prevalence of all dissociative disorders was an 18.3%. The most prevalent dissociative disorder according to DSM-IV criteria was DDNOS (8.3%). Dissociative amnesia was diagnosed in 7.3% of participants, DID in 1.1%, and depersonalization disorder in 1.4%. The prevalence of dissociative fugue as a solitary symptom was very low (0.2%) and observed usually as part of a more complex dissociative disorder (i.e. DID or DDNOS). In the DDNOS group, the prevalence of dissociative trance disorder was 0.6%, 1.1% had derealization without depersonalization, 4.1% had distinct personality states but did not fit all criteria for DID, and 2.4% had indirect cues for hidden distinct personality states (auditory hallucinations or complex behaviour for which they were amnesic).
Sagduyu, Rezaki, Kaplan, Özgen & Gürsoy-Rezaki, (1997) conducted a study with outpatients with conversion disorder of primary care clinic and found the prevalence of conversion disorder is 27.2% and the lifetime prevalence was 48.2%. Suggesting a high rate of psychiatric comorbidity; conversion symptoms were more frequent in patients with an ICD-10 diagnosis of major depression, generalized anxiety disorder, and neurasthenia. One-year follow-up of conversion disorder outpatients, most with non-epileptic seizures, found that nearly nine in ten patients with conversion disorder (89.5%) still met SCID-I criteria for a psychiatric disorder other than conversion disorder (Sar, Akyuz, Kundakci, Kiziltan, & Dogan, 2004). Using Turkish versions of the SCID-D and Childhood Trauma Questionnaire (Bernstein et al., 1994) the same study revealed that 47.4% of conversion disorder patients who had been hospitalised for a conversion symptom met lifetime criteria for a dissociative disorder. Compared to conversion disorder patients without dissociative disorder comorbidity, those who also met criteria for a dissociative disorder had more comorbid psychiatric disorders, childhood traumas, suicide attempts, and self-mutilative behaviours.

**Role of culture in psychotherapy**

Culture also incorporates the belief system, values, religion, etc. that will certainly affect the attitude of people towards treatment. For example, Muslims believe that jinns are creatures that humans cannot see, and they have power to enter our world and can affect our lives. Thus, it is understandable when a person visits faith healer first in order to get rid of his illness. The schedule of treatment is also conceptualised and adopted keeping the particular culture in consideration. Hoch (1990) noted the difficulties faced by her not only in psychotherapy with Indian patients, but also in training
psychotherapy to Indian students, and she accounted the difference of culture responsible for that. Thus, the effectiveness of therapies is not possible without understanding and inclusion of cultural aspects.

One of the goal and principle of psychotherapy is to make a client independent. And when we take Indian culture into consideration, people like to be directed rather than being given freedom to choose. Similarly, the therapeutic relationship is not therapist-client relationship but what is called “Guru-Chaila” relationship. Therefore, there is a need to re-explore this vast treasure of knowledge which may be culturally applicable and useful for Indian patients. What is needed is to make our patient aware of their hidden potentials. Cultural factors influence understanding, presentation, diagnosis, management, course, and outcome of mental illnesses. Thus, there is a strong need to understand the importance of culture in order to understand the phenomenology of underlying psychopathology as well as understanding different aspects of psychological therapies in the management of dissociative disorders.

**Conclusion**

Culture distinctively influences mental health of people living in a given society. At every stage of mental illness, course and outcome of mental health problems are influenced by cultural issues. It is pertinent to understand the cultural milieu of patient, as it can help to understand the patient and his psyche which influence the disease and healing process. Most psychiatric approaches to dissociation do not explore the socio-cultural meaning of dissociative experience and how these meaning influences its adaptive or maladaptive consequences which are based on individual archetype, class, society, and culture. A feature of dissociative vary from culture to culture; in
some cultures, dissociative phenomena around the world is considered to be completely normal and non-pathological, whereas in other cultures, the prevalence of dissociative disorder is higher than other cultures. In addition, dissociative disorders have different representations across cultures. Researches show that the dissociative disorders exhibit themselves either as a high prevalent disorder in a particular culture or as specific cluster of symptoms that are unique to that particular culture. For example, in Nigeria and India, common symptoms are feeling of heat, burning sensation of head and feet, peppery and crawling sensations, and these symptoms are very rarely found in Western countries. Thus, there is a strong need to understand the importance of culture in order to understand the phenomenology of underlying psychopathology as well as understanding different aspects of psychological therapies.

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The *cultural* genetics of mental health problems

Sneha Atal

What has ‘culture’ got to do with health, more so, with mental health?

Have you ever heard that so and so disorder is found in large numbers in a particular country/ region/ community? As practitioners in the field of mental health, we have all come across a number of symptoms, problem behaviours, or disorders being more common in a particular group of people, a specific community or people from a particular socioeconomic status. This implies that certain disorders or problems are caused or at least, aggravated due to a particular life style and habits. And what affects our way of living, the most? Most definitely, our “culture” – our beliefs, our rituals, our customs, and our overall mental make-up – all of these shape up our way of living.

So, we can easily infer that our culture and social diversity has a significant impact on the health problems that we have. Not just the diseases, even the mode of treatment and medication that we
choose, and also whether or not we seek treatment is largely decided by our cultural beliefs and customs. In case of mental health problems, the scenario is even more grave. In many societies, people consider mental health problems like depression, anxiety, phobia, etc. as a camouflage or an excuse on the part of the patient to escape undesirable situations. Naturally, the chances of coming forward to seek help for the patient and get him or her treated is out of the question in such scenarios. Consequently, these beliefs also influence how the patient is treated or cared for by the family members and other caregivers. As an obvious result, the chances of recovery get further decreased.

As far as cultural beliefs and practices in India regarding mental health are concerned, the situation is not quite amusing. In India and as such in most Asian countries, cultural practices give emphasis on following the social rules and controlling one’s emotions, and the freedom and acceptance of individuals as they are, is somewhat missing. Most people view their own mental illnesses as something to be highly embarrassed of and the approach of family members and caregivers is not very supportive either.

It is, therefore, imperative to work upon making cultural norms and beliefs more inclusive, and to foster an environment which is conducive to treatment and faster recovery of mentally ill patients. As long as the stigma and misconceptions attached with mental illnesses – both psychotic and neurotic – are not cleared, we may keep on researching about clinically and more sophisticated treatment and medications, but we will not be able to make any significant growth in improving the mental health scenario overall.

Let us also explore a little about what the scenario will be like if we pay a blind eye to this aspect. What will happen if we do nothing,
and let things and perceptions remain as they are? As mentioned earlier already, the chances and process of recovery will definitely be slow and in a lot of cases, will also decrease due to lack of proper understanding and inadequate treatment approach. For the holistic and wholesome treatment of a mentally ill patient, the most important factor is the attitude regarding the same – the attitude of the clinician, the patient, and more importantly, the attitude of the caregivers, family, and society at large. Suppose, due to the prevalent stigma, we as a society, let the statistics of depressive patients remain intact – what would the most probable mental status of the immediate next generation be? Again, what kind of an upbringing would a depressive parent generation be able to provide to the next generation? It is not difficult to foresee that we would be passing on our set of mental health problems to our following generations.

I once read somewhere that, “If you are not a part of the solution, you are a part of the problem”. So, being aware of the direct connection of our cultural beliefs, mentality, and life style with the mental health of ourselves and that of others around us, if we still do nothing to change any such deep-rooted cultural beliefs and rituals that might be hindering the treatment process, we are surely adding on to the gravity of the problem rather than solving it.

It is high time that we begin approaching mental health problems and their treatment process with a more holistic attitude that is more inclusive and embracing towards the patients. To have such an approach which would be conducive for faster and wholesome treatment of mentally ill patients, the first and most important step is to check the hindrances that our ‘culturally conscious’ psyches are thrusting in our way of patient care and understanding.
If not so, we ourselves will be passing on our mental illnesses to our children and future generations as a “heritage”.
CHAPTER VII

The trauma lens

Kantadorshi Parashar

An extremely distressing and disturbing event, trauma cuts out normalcy of life, and repeated exposures to the same induced by violence leaves scars that all clinicians have been well aware of. Going beyond the parameters of acute stress disorder or posttraumatic stress disorder, trauma also has layers that highlight an intricate relationship with the cultural experience. Trauma undercuts the usual, slashes unspoken assumptions to shreds, and attacks the very meaning of one’s life. And in the process of losing someone you dearly loved, trauma strikes hard (Larrabee, Weiner & Woollock 2003). Mental apparatus automatically attempts to regain psychic equilibrium by suppressing the affects that threaten to overwhelm it (Shapiro 1999). But, what if this attempt to regain psychic equilibrium is attacked by events following the trauma? The human experience of trauma though is universally understood, communicated, and empathised, the backdrops in which the responses to trauma occur are different based on the cultural realities surrounding it. Newspapers, post the 9/11 terror attacks, carried endless stories of hate crimes committed against immigrants from Middle-Eastern and South Asian countries. For the immigrant population, the violent attacks and the hate crimes- both in a foreign
land, calls for intervention practices that prioritises the person’s cultural experiences as much as the anxieties caused by the certain event.

Hutchison & Bleiker (2008) in their research on Emotional Reconciliation: Reconstituting Identity and Community after Trauma, quote:

“Traumatic events, such as wars or terrorist attacks, disrupt continuity and generate powerful emotions, most notably fear, anger and resentment. Dealing with the legacy of such traumas is a major political challenge. Gargantuan as it already is for many societies, this challenge is often exacerbated by prevailing ways of working through trauma. In most instances, political elites deal with the legacy of pain and death by re-imposing order. Emotions, such as fear, are often manipulated to justify particular policy approaches. A case in point here is the situation following the terrorist attacks of 11 September 2001 (9/11), when the US government employed a strong rhetoric of evil to gain broad nation-wide support for its wars of response in Afghanistan and Iraq. Similar patterns can be located in numerous other conflict situations, from the Middle East to the Korean peninsula. Such an appropriation of emotions may well help governments to achieve certain objectives. But they also contribute to building a sense of identity and political community that rests on a stark separation between a safe inside and a threatening outside. Dealt with in this way, trauma can come to inscribe and perpetuate exclusive and often violent ways of configuring community. Rather than solving the problems at stake, ensuing political attitudes can of produce new antagonisms or reproduce those that have created violence and trauma in the first place.”

The US-like reality though not entirely seen in the Indian context, all of us are well acquainted with the varied episodes of ethnic and religious conflicts that have tainted pictures time and again; and scattered instances of hate-crimes are not false either. Migrant
populations and minorities in India being the easy targets of such attacks call for a question if the issues have ever been addressed?

Often wrapped in challenges of adjustment, language differences, diverse food habits, and ritualistic dissimilarities, these populations, over generations of staying in certain places, do merge with the major identity; but, at the instance of traumatic event hitting the larger society, the differences re-emerge. The most infamous of this is the anti-Sikh riots of 1984. For a culturally diverse, secular, and “tolerant” country like ours, those riots reflect the underlying, often-suppressed from academic discussions of social psychology, the realities of stereotypes, prejudices, and discrimination that can take such extreme forms of forcing people to stages of trauma and grief. While constitutional laws rightly criticise all acts of discrimination based on race, caste, creed, or gender; a similar practical impact is definitely missing. Another major aspect here is that of children who, during their developmental processes are forming ideas about emotions, social relationships, and community functioning simultaneously. For the ones belonging to migrant or immigrant population, this comes with added demands of adjustment. It can be rightly assumed that unfortunate traumatic experiences place a larger toll on them.

Multiculturalism, when looked at from the perspective of trauma, calls for resources to be developed where we are able to address not only the victim, but also the perpetrators of such discriminatory behaviour, crimes, and overall hatred. Unless both the parties come on one platform, it will not be possible to fully resolve the complexities associated with discriminatory behaviour; and this only impedes the reconciliation process that follow traumatic events. Mutual participation in each other’s cultural festivities, common socialisations, awareness about the significances of cultural or
religious practices, creation of shared narratives and reference points can provide ample facilitation to knowing and understanding each other’s social realities. And knowledge, not ignorance, leads to enhanced acceptance and respect towards differences. Mental health as associated with cultural diversity is not an issue to be dealt with in isolated clinical setups, rather they require awakening of an entire community of people. It gains further importance at the face of the current day truth of recurrent violence where the root of difference is the divide that is created and perpetuated by violence. If this cycle is not broken down by knowledge of each other’s perspectives, one united stand against these trauma-causing agents will not be possible.

The fact surrounding this entire issue is that unless we, as global citizens and human beings do not start from our homes, our communities, and our neighbourhoods a willingness to know the minor and major populations around us (of which we may or may not be a part), a bigger change is less likely. Psychotherapy sessions are not the solution to growing intolerance; it is rather an approach of knowing and acknowledging one-person-at-a-time in the societies we live that can help us prevent from differences worsening, and definitely provide us more shoulders to support us at the advent of trauma. Contrary to popular beliefs of collective identities erasing individual identities, does standing collected not make us more resilient and mentally healthier?

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Cultural diversity and mental health: Mexico

Claudia Juarez

Mental diseases are considered a serious problem around the world with elevated costs that affect millions of people, no matter their age, gender, financial status, or cultural level. They also represent one of three main mortality causes in population between 15 to 35 years old.

In Mexico, we live a transition from infectious-contagious to chronic degenerative diseases, in which mental diseases take part of them. As some other parts around the world, depression is a major concern for women and men: first place for her, and fifth for them, which also suffer substance abuse, like alcohol, as sixth cause of mental disease.

In despite of the results, according to a National Survey, use of medical and psychological services are underused by population: one in every five receive specialised attention for affective disorder, and one in every ten for anxiety disorder, delaying four up to 20 years,
depending of the disease. Mental health stigma can contribute to this.

Government authorities also recognise that for the entire budget dedicated to health, only two per cent is for mental health. From this, 80% is used to maintain psychiatric hospitals, and most of them are in the major cities or around them, that represents a big hole in the rural areas.

Besides hospitals, there also are ambulatory mental health services that reach up to six times the hospital users, but most of them are adults, leaving again a great opportunity for children and adolescents’ attention.

Primary healthcare attention is considered an important issue, but once again, they recognise there are also few institutions that have mental health professionals like psychologists or others that can make mental health prevention and promotion.

Moreover, across the country, there are many cultures and subcultures that require our attention. From North to South, although there are some similarities, no one can doubt there is a lot of opportunities to develop mental health programmes that cover specific population needs.

In the North of Mexico for instance, migration can take a toll in mental health. According to Conacyt (National Counsel of Science and Technology) although in convenient circumstances, migration implies separation, as some degree of grief and new challenges to a new social and cultural environment. All of these elements can create a considerable amount of stress that can contribute to mental health problems. Many immigrants show a variety of stress symptoms including emotional (depression or anxiety), physical
(headaches and fatigue), and cognitive (concentration difficulties and confusion).

Due to the new policies, many immigrants are returned home in difficult circumstances in which individuals have any or no control. This can also might lead to mental health problems.

For those who live in major cities, violence, pollution, and conglomeration among other important stressors, affect millions of people and this, as we know, can heighten the risk to suffer depression, anxiety, and other psychiatric disorders, even increasing schizophrenia risk.

If we consider that main attention is given around these cities, we must think that problem is solved, but unfortunately is not, due to the capacity of public services, mental health stigma, and some other factors as explained above.

We can also look at other important groups such as psychosocial disabilities persons that according to a study suffer from systematic abuse of their sexual and reproductive rights; or mental health problems of LGBT individuals associated with discrimination and marginalisation, that can lead to depressive symptoms and substance abuse.

There is no a one-size fits all for mental health programmes. Although mental diseases are common, it is important to understand the causes, implications, and development in every case.

As I also mentioned earlier, mental health problems arise in childhood. That is why mental interventions should start during this important period of life. Most common issues reported and viewed in the private practice are related to domestic violence,
abandonment from their parents (physical or psychological), substance abuse and school problems associated with behavioural issues, bullying and peers’ pressure. In my humble opinion, target interventions should be focused in the first years.

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CHAPTER IX

Intercultural awareness and competence: a professional diary

Bornali Das

North East is the land of multi ethnicity, multi religiosity, and multi linguistic society. It is also the confluence of races like Indo-Aryan, Austro-Asiad, Tibeto-Burman, and Mongoloids. The region is place of admixture of population with varied cultures, language, beliefs, and indigenous long settled inhabitants from adjacent countries and North Eastern states. The language, the native of Assam is called as Assamese or “Axomiya” (Encyclopedia of Asian History, 1998).

Culture is a “collective mental programming”, the way we share our beliefs, values, religion, healthcare perception and practices, behaviour and roles of family, norms of society, economic cost, politics and legal provisions systems are all part of our culture (Hofstede, G. Bond, M.H. & Luk, C.L. 1993). Society and communities are in constant flux; so as the thoughts, values, and beliefs. Movement of people and their ideas setting the goals of globalisation and developments has led to culturally diverse
heterogeneous thoughts. To the best interest of our communities settled here, they maintain relations to well-meaning cultural intersect amongst diversity.

Diversity means understanding that each individual is different, yet unique. Differences could be in race, gender, ethnicity, socioeconomic status, age, physical ability, religious beliefs, political beliefs, or ideology. Today’s diversity is embracing, accepting, and celebrating the differences.

Dealing with emotions and mental health, as observed historically that it was long appreciated as peaceful community living in North East. But over the years, it has turned to gross intolerance, ethnic violence, insurgencies leading to barriers in accepting others religion, beliefs and ideology, ethnicity, disability and disease. These barriers are seen further more when there are language barriers, cultural incompetency, incompatibleness, poverty, law and legal rights violence leading to ‘social exclusion’.

**Cultural empathy**

Through globalisation and easy communication, world has compressed to a village; but, we need to be aware of the forthcoming challenges that comes with intercultural interactions and different communications styles (Beer, J.E. 2003). Learning and sensing the language in verbal as well as non-verbal would be the first step towards acceptance to sense their understanding and communicating with the people including making sense of communication styles, cultural values, attitude, and shared beliefs.
Need for intercultural awareness as professionals

As person knowing to understand one’s own cultural ideas and attitudes, professionals should know how to feel comfortable in another’s culture. The habit of looking down upon the other cultural group and self-impression of superiority on own cultural group, best hinders the level of acceptance (ethnocentrism). Intercultural awareness is also about assimilating and understanding that we share the same basic goals of life. People from all cultural groups and communities want to be treated with dignity and respect in order to live a healthy life. When not treated adequately, birth of marginalisation, vulnerabilities, and socially exclusion rises up. These negative feelings can affect our families, communities, and societies at large leading to inbreeding of own biases.

Skills of cultural competence

Communication is vital medium of existentialism in diverse society. Possession of the knowledge, skills, and the ability to understand, appreciate, and interact with persons from across cultures and their belief system is “competence”. Professionals need to imbibe adaption skills like coping with the transition to new culture, open-mindedness, absence of intolerance and biasness towards others’ behaviours and cultures, cross-cultural communication skills, how we need to watch, listen, and accept the differences of others and build trust, largely negotiation skills by reconstructing, by dealing with interaction and joint decision making.

Intercultural sensitivity

Despite being aware about the differences in culture, we are being able to accept, adapt, and integrate with the differences. It is pertinent to guide people and professionals in intercultural
interactions. Few skills include **intercultural awareness**; this skill will help persons understand the context and the symbols that affects thoughts, emotions, and behaviours. Secondly, **intercultural sensitivity**; being aware and feel positive, respecting cultural differences and sharing the deficits of own culture and overcoming biases. Thirdly, **intercultural competence**; through skills, knowledge, and awareness, knowing what to share. While handling ethnically diverse clients in place like North East, one need to prove “competence with sensitivity”. Intercultural competence will help mental health professionals to inculcate better intercultural skills and building relationship between individuals and environment.

While encountering clients and patients, we as mental health professionals in North East understand multicultural diversity as essence in all aspects of promotion and well-being for prevention, intervention, and treatment. Professionals need to “foster cultural humility” (Teravalon, M. & Murray-Garcia, J.1998) and responsive enough to the needs of the people. Culturally and linguistically competent system not only incorporates skills, attitude, and policies, but ensures to effectively address the needs of people and families with diverse values, beliefs, and orientation. Cultural humility is a lifelong commitment to self-evaluation and self-critique; it helps to redress imbalances in the patient-physician dynamics, develop mutually-beneficial and non-paternalistic clinical and advocates partnerships with communities on behalf of individuals and defined populations.

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Cultural diversity and mental health: Fiji

Balram Pandit

Introduction

Falling well in line with basic tenet of this universe, cultures across the globe is diverse and dynamic. It is more of later cultural characteristic which earns the essential equilibrium, leads to evolution of newer cultural traits, and perpetuation and progression of human civilisation in today’s rapid mixing multicultural world. Culture can be considered as a set of subjective values that oppose scientific objectivity, but this notion gets challenged by it’s this dynamic property, which opens the door for change and acceptance (Napier et al 2014). Mental health being heavily influenced by this dynamic socio-cultural value system gets primarily affected by it. Culture and its components can have wide ranging impact on assessment and management of a client. It should be considered right from the first interaction with the individual and their families, as it influences not only the evaluation, compliance, engagement with services, and expectations of treatment, but also impacts upon identity and explanatory models of individuals (Bhugra 2006).
Dementia, in many parts of India is still considered as “Sathiyana” (sexagenarian problems/phenomena) or known by other terms which are conceptually same, but look different in different language and vernaculars. The sufferers as well as their family members start feeling that this is how life is! The scenario is more or less similar in many cultures across the world, especially in eastern hemisphere. Fiji, the pacific hub, another multicultural society has similar concepts in its majority I-taukei (“Qase guiguileca”) and Indian communities. This socio-culturally cool but scientifically ignorant concept keeps people pacified and allows family members to care for the suffering elderly in culturally correct way. On the contrary, awareness and recognition of the same problem as medical illness can leave many people from some culture surprised and anxious, if not revealed and tackled by the therapist tactfully and culture appropriately.

People have started calling modern Western culture a health hazard (Eckersley 2006). This culture of materialism and individualism is deliberated as detrimental to health and well-being through their impacts on psychosocial factors, such as personal control and social support. Many psychological studies have shown that materialism is associated, not with happiness, but with dissatisfaction, depression, anxiety, anger, isolation, and alienation. Human needs for security and safety, competence and self-worth, connectedness to others, and autonomy and authenticity are relatively unsatisfied when materialistic values predominate. On the other hand, individualisation has been a progressive force, loosening the chains of religious dogma, class oppression, and gender and ethnic discrimination, and so associated with liberation of human potential.

The notion and celebration of “cultural unity within its diversity” sounds as incoherent as thought of centre without periphery. With
advancing globalisation (where in disguise of modernisation, one culture and its cultural components appear to be dominating), the damage to cultural diversity seems inevitable. Needless to say, this will deny us not only the benefits of genuine differences, but also the different kinds of knowledge that characterised humanity in former times. In nutshell, as cultural diversity and biodiversity give way to global homeny, both other ways of thinking and potentially important ethno-pharmacological resources are jeopardised (Napier et al 2014).

The world has started realising the shortcomings of medical model of mental illness and the merits of cultural components, which are helpful right from evaluation to management. When used judiciously, these interventions are cost-effective as well. It is heartening that this realisation has made culture appropriate assessment and intervention, a prominent and integral part of “Global Mental Health Movement”, WHO-MhGap training programme and has given it due place in many Govt. policies including National Mental Health Policy of India-2014 (NMHP 2014). Traditional methods of healing can play a substantial role in a client’s recovery, such as spiritual and religious practices, yoga, meditation, special diets, and massage. If we educate our clients on mental and psychological problems with genuine empathy, compassion, and care, we can improve their access to services and, as a result, a positive therapeutic outcome (Mehraby 2009). Consideration of this cultural side makes management more holistic in real life setting. However, its successful delivery demands cultural competence (CC) of health professionals.
What is culture and cultural diversity?

Culture has been defined in various ways. The anthropologist Robert Redfield (1941) once elegantly defined culture as “conventional understandings, manifest in act and artefact”. It focuses not only on shared understandings, but also on practices that are based on those understandings and that make sense of beliefs held in common with others. Dwight Heath (2001) defined it as: “It [culture] is a system of patterns of belief and behavior that shape the worldview of the member of a society. As such, it serves as a guide for action, a cognitive map, and a grammar for behavior.” Moreover, it has also been defined as a set of behavioural norms, meanings, and values or reference points utilised by members of a particular society to construct their unique view of the world, and ascertain their identity (Chowdhury 2012). It comprises of number of determinants, such as language, customs, ethos, rituals, traditions, etiquette, taboos or rules, spiritual beliefs, moral standards and practices, socioeconomic status, and gender and sexual orientation. Culture is learned, shared and patterned. It has adaptability and has symbolic component with arbitrary signs representing something special to that particular community.

Cultural diversity embraces the cultural differences that exist between people, such as language, dress, and traditions, and the way societies organise themselves, their conception of morality and religion, and the way they interact with the environment. The Universal Declaration on Cultural Diversity was adopted by UNESCO (2001) as it affirmed cultural diversity as “common heritage of humanity”, where the key emphases are: (a) the diversity of people’s backgrounds and circumstances is respected and treasured, (b) availability of similar life opportunities to all, and (c) strong and positive relationships exist, and continue to be developed
in the workplace, in schools, and in the wider community and society. Cautious and ethical consideration of cultural diversity is a crucial issue in psychiatry as it aims to integrate culture consciousness and culture sensitivity into clinical education, training, and practice, which influences the quality of mental health service delivery to individuals from minority ethnic communities (Bhui & Bhugra 2002).

**Perception and interpretations of mental illness in different cultures**

Historically, mental illness in most cultures, including some Western cultures, has been viewed in a religious and spiritual context. In India, which as country and subcontinent showcases diverse macro and micro cultures, “Law of Karma” is overall prominent, especially in traditional societies and families. Any major life event including illness in general and mental illness specifically is interpreted as result of “Karma” of either present or past life. Similar belief system can be observed in other neighbouring countries, including Myanmar, Thailand, Cambodia, and Vietnam, as the same principle echoes in basic ethos of Buddhism, a faith of majority in these countries. However, Japanese view mental illness as a particularly undesirable form of weakness in the person; shame and stigma prevents people from seeking help and in China, mental illness can be perceived as a form of possession by an imaginary demon or an evil spirit.

Afghan people with mental illness are considered crazy or possessed by Djinns. There is no concept of psychological problems in the Afghan culture; people are considered either healthy or ‘mad’. In most African countries, such as Sudan, Ethiopia, Somalia, and Kenya, it is often believed that supernatural agents can possess a person and might cause physical and/or psychological disorders. In
Morocco, it is believed that mental illness is caught like a cold while out walking in a state of absent mind, someone can step on a bit of sorcery or might drink it accidentally. Social reputation is of significant value in Arabic culture and enormous efforts are made to avoid any shame that may endanger the family reputation; so, a person with mental distress may not seek advice from professionals, or even family members (Mehraby 2009). In Oceania, person with mental illness is viewed as being cursed or affected by the work of witchcraft, a sorcerer or the devil’s eye; but, on the contrary, some illness in some part may be interpreted as religious awakening or a holy message from God. In Fiji, the commonly used term “Lialia” (mad or insane) appears more stigmatising than “Tauvimate ni vakasama” (mental illness).

**Culture and substance abuse**

Sociocultural beliefs can form the approach and behaviour pertaining to substance use and abuse. Culture has a key role in creating the expectations of individuals about potential problems they may come across with drug use (Heath 2001). An US study confirmed the high abuse of alcohol and use of illicit drugs in acculturated Hispanics (Abbott & Chase 2008). Illegal drug use in the previous month and increased alcohol use were found to be 7.2% compared with less than one per cent of non-acculturated Hispanics and 6.4% of Whites. Non-acculturated Hispanics who were recent immigrants, were reported to be more family oriented and had lower rates of drug and alcohol use. Thus, the study concluded that ostensibly, indigenous cultural values have a protective effect.

Illicit drug in one culture can be not only socially well acceptable in other cultures, but can also be observed to be part of many religious
occasions, major life events, and general life style. Bhang (Cannabis S.) in various forms especially bhang shake is freely distributed on final day of many festivals in Northern India. Because of increased demands by public and its social acceptability, recently cannabis use has been legalised in some European countries and some states of US. The voice for medical use of marijuana is also gaining strength in some parts of the world, especially in Western culture. In Fiji and other neighbouring countries of South Pacific “kava” (which in low dose works as anxiolytic) is very popular and is integral part of daily life, for majority. Be it an auspicious event or inauspicious event (death ceremony/anniversary), kava always gets its due place. A big religious formality is observed before offering it to the Deity and national guests. Furthermore, it is culturally advised that for meeting with any village head one should present kava as gift than anything else. Also, Pacific Islanders, especially in Western part, appear to use combination of arecholine and nicotine in a very unique way. They usually partially divide the raw betel nut (Areca) with its cover still around and insert cigarette, lime, and where available, betel leaf inside before closing it and chewing it. This habit again happens to be an integral part of the culture. It is socially approved, used in daily life as well as ceremonial situations, and exchanged as gift.

Overall, the problems that drugs and alcohol bring to communities are multidimensional. Hence, interventions should be designed in liaison with the community. Because, it is in this task of community healing that hope is resurrected, this hope is vital in initiating and driving the healing process. Thus, tribal groups, families, traditional healers, faith based bodies, legal authorities, and community mental health workers should all be involved in the healing and recovery process (Abbott & Chase 2008).
Cultural diversities and psychopathologies

Tseng (2003) provided an elegant practical clinical construct about impact of culture over psychopathology. He proposed seven types of effects:

A. Pathogenic effects: Talk about circumstances where culture is a direct causative factor in creating psychopathology, e.g. culture-bound syndromes (koro, dhat syndrome, latah, spell, susto, etc.). Koro, a syndrome associated with acute fear of retraction of sexual organs inside body is common in male, but can be found in female as well (Srivastava & Pandit 2013).

B. Pathoselective effects: Cultural choice to stress response that profiles the nature of psychopathology, e.g. running amok.

C. Pathoplastic effects: Methods in which culture contributes to the manifestation of psychopathology, either by shaping the content of the symptoms (content of delusions, hallucinations, obsessions, or phobias is subject to psychosocial context of the reported pathology) or modeling the clinical picture as a whole, e.g. taijin-kuofu-sho in Japan.

D. Pathoelaborating effects: Some behaviours (either normal or pathological) can get exaggerated to the life-threatening level by cultural reinforcement, e.g. hara-kiri in Japan.

E. Pathofacilitative effects: Many psychiatric disorders are closely tied to psychological and sociocultural elements in their development, e.g. suicidal behaviour.
F. Pathodiscriminating effects: Sociocultural labelling of behaviour as normal or abnormal behaviour, e.g. sexual deviation and substance abuse.

G. Pathoreactive effects: Culture influences how people label a disorder and how they emotionally react to it. Prognosis of schizophrenia is better in third world countries and rural areas than in developed countries. The family and social environment, family attitudes and resilience, and community support contribute significantly in the overall rehabilitation of the person, on the road to recovery. Thus, this difference in prognosis.

**Culture and LGBTI people**

Across the cultures, mental health appears to be a low interpretation of problems associated with lesbian, gay, bisexual, transgender, and intersex (LGBTI) people in different cultures. But, in demonstrating considerable resilience, LGBTI people share a similar story with people who have experienced mental health issues, particularly in how they have overcome self-stigma arising from identity issues, loss of self-esteem, and discrimination. Many LGBTI people are adversely affected by multilayered discrimination, marginalisation, and stigma. Risk factors for their mental health include violence, bullying or rejection, and discrimination from school, family, friends, and workplaces, and from society more generally. Moreover, risk factors for intersex people can include harassment, involuntary adaptation to gender norms, or pain and scarring from childhood genital surgeries or forced hormone use (Haas et al 2011). LGBTI people can be helped in their recovery by their families, by educational institutions and workplaces, by their friends and partners, and by mainstream services and community-specific
CULTURAL DIVERSITY AND MENTAL HEALTH

support and community groups. Mental health services that are culturally competent can also be influential in supporting recovery.

Cultural diversity as challenge in assessment and management

Cultural diversity poses challenge primarily to the very foundation of clinical practice which is establishing a rapport and sound doctor-patient relationship through a meaningful interaction. Cross-cultural communication is a process of exchanging, negotiating, and mediating one’s cultural differences through language, nonverbal gestures, and space relationships. Cultural background, health beliefs, and treatment expectations affect healthcare encounters with every patient (Kai 2005). Different cultures have different ‘set rules’ that influence the behaviour, pattern of speech, value judgement, concept of time and interpersonal space, and emotional attitudes towards distress and dysfunctions. Health professionals should be aware of cognitive, behaviour, and the emotional constraints, as it may interfere with effective cross-cultural communication (Ting-Toomey 1999).

Cultural difference in communication can occur in form of: (1) Different communication style, (2) Different approaches to completing or handling things, (3) Different decision making style, or (4) Different attitude toward disclosure (DuPraw & Axner 1997).

Factors like lack of cultural understanding, health professional’s personal value, judgemental attitude, tendency of prejudice, discrimination on socio-cultural differences, generalisation, stereotyping, racism, ethnocentrism, cultural blindness, cultural imperialism, and cultural impositions can also lead to impedance in cross-cultural communication (Chowdhury 2012).
Cultural competence in assessment and intervention

Studies and official reports (Report of the Surgeon General 1999) showing healthcare disparity due to cultural incompetence generated the demand for culturally competent health professionals. Cultural competency (CC) is “a set of academic and personal skills that allow us to increase our understanding and appreciation of cultural differences between groups” (Cross et al 1989). Becoming culturally competent is a developmental process (Chowdhury 2012). A culturally competent health professional should always keep in mind the possibility of issues pertaining to lack of awareness, diversity, and expectations. Lack of awareness of these differences in clinical setting can be overwhelming and result into miscommunication, rejection, or cultural distance. At individual level, cultural competence comprises of five components (Papadopoulos et al 2004): (1) Cultural desire, (2) Cultural awareness, (3) Attitude towards cultural differences, (4) Knowledge of different cultural practice and world views, and (5) Cross-cultural skill.

An outline for a culturally relevant case formulation framework is based on five major components: cultural identity, cultural explanation of the illness, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the relationship between the individual and the clinician, and overall cultural assessment for diagnosis and care (Ting-Toomey 1999).

Conclusion

Culture counts a lot, especially in cross-culture clinical practice. Absence of awareness of cultural dimension of scientific practice can lead to perceived distinction between objectivity of science and subjectivity of culture. In broader perspective, culture not only embraces social systems of belief as cultural, but also presumptions
of objectivity that permeate views of local and global health, healthcare, and healthcare delivery (Napier 2014). Thus, there is need to preserve diverse cultural assets which helps in achieving overall mental health and wellbeing. Unity within diversity in a multicultural society seems need of the hour, but certainly not at the cost of crucial components of diversity.

In recent decades, the overall prospect of mental health and wellbeing has broadened to an extraordinary extent. There is a substantial change in the medical ethics of interventions and procedures with more focus on human rights, ethnic relation, gender equality, and immigration health within national standards and judicial framework. Hence, it is now becoming a primary issue in all communication and policy frameworks. It is also encouraging that many of the major international health organisations, including the World Health Organization (WHO) and the World Psychiatric Association (WPA) are becoming the vanguard in taking the cultural issues in the forefront of medicine and mental healthcare, and thus enriching our perception, attitude, and thrust for cross-cultural knowledge in a very positive way. Furthermore, cultural diversity, competency, and cultural formulation are becoming a part of healthcare system, medical education (Marzan & McEvoy 2010), and psychiatry training programme in some of the universities and healthcare organisations.

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Towards holistic health and wellbeing: journey of MIND India

Sangeeta Goswami

Our vision
Positive Mental Health & Wellbeing for All

Our mission
Enable People to “Choose Change”

Today, health professionals the world over are emphasising on the fact that positive mental health plays a significant role in achieving positive physical health. But sadly enough, developing nations, still struggling to achieve targets of basic health amenities, have not been able to give due weightage to this fact. In India, mental health facilities, in common parlance, is synonymous to mental asylums and hospitals; awareness about the facts that govern positive mental health is almost next to nothing. Moreover, the social stigma associated with even the slightest mental malady makes this a taboo subject even for the enlightened section of the society. According to
the World Health Organization, “7.5% Indians suffer from major or minor mental illness” (Times of India 2017) and by 2020, the emotional health of humanity will decline drastically if the status of mental healthcare and intervention do not change. However, with timely and appropriate intervention, maximum of them can recover as well as avoid chronic illness and disability.

In Assam, though there has been a change in the health sector over the last three decades, much emphasis is yet to be placed on conventional medical practices. However, the growth in the requirement of psycho-social intervention and counselling for people from all walks of life is an indicator that the rigours of the present day world have already made their presence felt in this region and require resolving.

The noticeable gap between the technological advancement of recent times and the rate of change in social structures and system, has been an area of great concern for social scientists, educationists, policy makers, and legislators alike. Though this affects the entire population, the effects are more pronounced in the lives of children, adolescents, and the youth. From the perspective of the discipline of positive psychology or holism, mental health includes an individual’s ability to enjoy life, procure a balance between life activities and efforts to achieve psychological equilibrium, and thereby, mental resilience. Mental health problems range from everyday stressors like meeting deadlines, communicating with various people, planning finances, attuning to others viewpoints, and the worries and grief we all experience as part of living, to the most bleak, suicidal depression or complete loss of touch with everyday reality. Positive mental health dwells on prevention rather than treatment, on flourishing rather than illness, and on strengths rather than weaknesses; so that, it enables individuals and communities to thrive.
Positive mental health is about:

- feeling in control of ourselves
- being able to make rational decisions
- being in touch with our feelings
- being able to form positive relationships
- feeling good about ourselves
- knowing how to look after ourselves

Based on this premise, MIND India, Institute of Positive Mental Health & Research, Guwahati, Assam was established in January 20, 2006 by a group of professionals, dedicated to the cause of ushering in the benefits of positive mental health and wellbeing to the general population at a national level. The group has been working relentlessly since its inception to meet its objectives, especially in the North East region of India, comprising of the states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Tripura, and Sikkim.

The objective of MIND India is to create an opportunity to bring together stakeholders from various sectors to meet and deliberate on positive psychology, so as to ensure healthy lives and wellbeing at all stages of life. The pathway undertaken by MIND India to attain its objectives is modelled on the concept of assessing needs at the grass root level, deconstructing the same to arrive at the deeper issues surrounding that particular concern, and thereafter, putting together a methodology to address the same in the most appropriate manner. Thus, any activity in MIND India follows a loosely structured model comprising of need assessment, data collection, and dissemination of information, appropriate training, intervention, and rehabilitation as and when necessary. The organisation provides technical support based on evidence based research inputs, so as to build capacity of
manpower at different levels for healing and personal growth which will in turn enhance personal effectiveness.

Reference

Times of India, 25/02/2017.
CHAPTER XII

Destination: a real home for persons with special need

Monmi Das

With registration number RS/KAM/240/Y/281 of 2005-2006, Destination’s advisors are Mr G.M Srivastava and Ms Rupa Hazarika, who is the founder of Destination and member of the Assam State Commission for Protection of Child Rights (ASCPCR). Ms Minakshi Changmai Das is the President, Ms Monmi Das is the Vice President, and Mr Bikram Singh is the Secretary.

About the organisation

Destination is a non-profit non-governmental organisation (NGO) working for the welfare of individuals with mental health condition, children and adults with special needs, such as mental retardation, autism, cerebral palsy, Down’s syndrome, attention-deficit/hyperactivity disorder (ADHD), etc. It also believes in providing lifelong custodial care for economically deprived persons. Destination was established on 1st June 2005 at 59, Bhagaduttapur, Kahilipara, Guwahati-781019, Assam, India. It also works for the welfare of other needy sections of society, child and women welfare,
environmental protection, etc. It is a non-political and secular organisation.

**Registrations**

Destination is registered under:

1. Society Registration Act XXI of 1860
4. 12A Registration under Income Tax 1961
5. 80G (5)(vi) Registration under Income Tax Act 19616
6. Juvenile Justice Care and Protection Act

**Vision**

Destination aims at providing an ultimate solution for the mentally challenged persons, especially roadside destitute, so that they may get enough opportunities to get educated, avail medical services, participate in community activities, and enjoy all basic human rights. It also emphasises on the protection of child rights.

**Mission**

To ensure the quality of life of each and every mentally challenged person, including the roadside destitute, treat them as equal normal human beings, and empower them to live independently by providing residential rehabilitation services to the maximum extent possible, and advocacy and campaign to raise awareness in society.

For long 18 years, Destination has sheltered special children and adults who need support in performing independent skills. They have been provided with vocational, music, dance, drama, and academic education.
Destination also provides support and care to the homeless, abandoned mentally ill persons loitering on the streets. It provides medical advice/treatment along with psychiatric counselling with the support of the Social Welfare Department, Govt. of Assam and Ministry of Social Justice and Empowerment, Govt. of India.

With a view to showcase the talents of the differently abled persons, a stall named ‘Shilpa’ was started at Shilpagram, Panjabari, Guwahati. Revenue generated from the sale is reinvested back into the programme.

On April 2013, the Guwahati School of Computer Education was established by Destination for the upliftment of schedule castes, schedule tribes, and differently abled children.

Among the various awareness programmes conducted by Destination, the following are worth mentioning:

1. One day programme on sanitisation and advocacy for the Persons With Disabilities (PWD) Act for parents having children with disability.
2. One day programme on sports cum creative arts with the support of the National Institute for Empowerment of Persons with Multiple Disabilities (NEIPMD), Chennai under Ministry of Social Justice and Empowerment, Govt. of India.
4. One day programme on exhibition cum awareness for children with disability.

Destination believes in paving the way to raise awareness on mental health issues, empowerment of the physically challenged, and to make them better citizens of society, despite their various handicaps.
Cultural diversity and mental health

Sohini Banerjee, Arabinda N Chowdhury

“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 globalisation 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 that shape their norms, customs, practices, social rituals, behaviours, psychological processes, organisations, language and the material objects created by members of a given group that are often inherited by the next generation (Schafer R, 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 ethnicity 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 behaviour including methods of treatment, approach to protective and remedial measures, outlook towards healthcare 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 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 led to multiculturalism, a phenomenon reflecting cultural diversity within a society (Howarth & Andreouli, 2013).
Globalisation 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.

**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 cause 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 intra-familial code of cultural transmission (Wiese, 2010).

**Acculturative stress**

It 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**

It is the experience resulting from of loss of social, structure, cultural values, and self-identity in the new cultural environment (Eisenbruch, 1990).

**Diaspora**

“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**

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 posttraumatic stress disorder (PTSD) (Bhugra et al, 2011).
Multicultural India

India is a country characterised by geographical, racial, ethnic, linguistic, religious, social, economic, political, and cultural diversity. According to the Census of India (2001), approximately 307,150,000 Indians of which nearly 14.0% migrated internally to different parts of the country from their places of births and 13% from their last location of residence. In addition, India is home to 6,167,000 migrants. Thus, as a result of increased transnational movement healthcare providers are increasingly coming in contact with people of different ethnicities, cultures.

The process of migration may include a feeling of displacement, estrangement, and separation which in turn could give to stress and mental illness (Bhugra D, 2004). People of any age, religion, geographical location, race, ethnicity, socioeconomic 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 housewives 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 recognised 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 pathalogical 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 behaviour:** The preferred treatment or help-seeking depend on the patient’s (or family members’) EMI. 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 standardised Western assessment instrument is not desirable. For several years, the contribution of culture in the
articulation of psychological symptoms remained unacknowledged (Ware and 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 (Arrendondo 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 World Health Organization (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 utilisation. 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 prevalence of certain mental disorders across the world, nevertheless there are considerable divergences too. For example, 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 two per cent to 19% across nations. Research has indicated that heredity plays a
significant role in disorders like schizophrenia and bipolar disorder, as compared to depression, 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, 2012), 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 DSM-5 (American Psychiatric Association 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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