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Abstract Book

FIRST DAY - September 27 (Sunday)

Welcome & Historical Address

Norcia and the Benedectine Monacus-Medicus

G. Bartocci (*Italy*), M. Kidson (*Australia*), A. Hornblow (*New Zealand*)

1. Norcia: a short history

The highlands around Norcia were once a lakebed, in the Pliocene geological era, with human occupancy of the region since Neolithic times. The empting of the lake left a fertile plain that, notwithstanding the altitude and the winter snows, made the inhabitants of the area the beneficiaries of significant natural resources. Woods and rivers were a rich source of food and timber, and settled occupation provided crops and the raising of stock from cultivated land. Legumes were well know and appreciated for their taste in early Roman times. The geographic isolation of the highlands influenced the psychological climate of the local population, who being remote from the major centres of population and culture accepted a simple and solitary style of life. These highlands became the home of the Sabine tribe, known for their austere lifestyle.

The oldest record of human habitation in Norcia presents a mystery - the finding in 1900 of an Etruscan chariot, dated around 530 BC, and now in the Metropolitan Museum in New York. This archaeological find is intriguing, as Norcia is far distant from known areas of Etruscan settlement. By contrast, subsequent Roman links with Norcia are well authenticated, several documents providing evidence of the granting to the town of Norcia, in 290 BC, the title of CIVITAS SINE SUFFRAGIO, i.e. Roman citizenship without the right to vote. In 41 BC the town was conquered by Octavian, a grandnephew of Julius Caesar, whose troops enclosed it with a fortified wall. Christianity made its appearance in

Norcia in the third century, through two different migrations of evangelising monks. Noteworthy among them is the figure of Eutizio, who was the model for the young Benedict.

When the Roman Empire fell, Norcia was led by a local government elected by popular vote through a democratic process. A French encyclopaedia states that: "Norcia is a small town in Umbria. Although under the control of the Holy See, it has always had a form of republican governance". Throughout the Middle Ages Norcia experienced various local conflicts, in particular with the towns of Visso and Ascoli, in the process producing its own warriors and venture captains. In later and perhaps less troubled times, Norcia is recorded as having established a university, in 1615, as documented in a statute dated 1677, now in the archives of the Capitolino in Rome.

Following the unification of Italy in 1860 Norcia became a Commune d'Italia, subsequently undergoing urban development. The establishment of the National Park of Monti Sibillini, in 1989, has led to the town becoming a popular tourist centre.

Norcia is famous for being the birthplace of Saint Benedict, whose statue dominates the town square. The town also honours Benedict's twin sister, Scholastica, who became a nun and the leader of a religious community near that of Benedict, is said to have visited Benedict once each year, and is regarded as the patron saint of nuns. St Benedict is regarded as the founder of the Rule governing the life of the Benedictine and Cistercian monasteries. The root meaning of the Latin word translated as "rule" is *trellis*, a framework on which things may grow. Benedict's Rule, developed as the Roman Empire collapsed, became the comprehensive framework for daily life in religious communities, a framework which was to develop the religious, practical, and scholarly life of these communities. In 1964 Benedict was nominated as the Patron Saint of Europe by Pope Paul VI. The Pope indicated Benedict's Rule as the cultural root of the CHARTA CARITATIS, or "Charter of Charity", of Citeaux Abbey, compiled in 1119 and lately considered as "the first European constitutional act based on democratic participation".

2. Benedict the man - Benedict the saint

The Encyclopaedia Britannica describes Benedict as the patriarch of western monks. Between his death in 547 and the days of Charlemagne, crowned Emperor by the Pope in 800 AD, Benedict's message, and his codification of the rules for religious communal living, spread gradually throughout Western Europe as the bulwark of Roman Christian heritage. Up to the twelfth century Benedictine monasteries were the prime repositories of learning and literature in Western Europe and the principal educators of the children of the aristocracy, and also the laity.

The only authority for the facts of St. Benedict's life is Book II of the *Dialogues* of St. Gregory the Great, Pope Gregory the First, dated 593 AD, fifty years or so after Benedict's death. This account is clearly written to affirm Benedict's life and status as a saint of the Church, with prominence being given to acts purporting to show his special and supernatural powers. It is also possible to get data on St. Benedict from the much later (1260 AD) *Golden Legend* by Jacobus de Varagine which, although very similar to the information from Gregory the Great, leans more to "scientific history as distinguished from sacred or salvation history".

Benedict was born into a noble family in Norcia around 480 AD, just after the decline and definitive fall of the Roman Empire in 476. He was sent by his parents for schooling in Rome, but, shocked by the chaotic situation there, he fled to settle in a remote grotto in the hills near the ruins of Nero's palace in the town of Subiaco, 40 miles or so from Rome. His self imposed isolation in this cave was unknown to all except Romanus, a monk of a neighbouring monastery, who clothed him in the monastic habit, as an act of charity and not as an initiation. Romanus secretly supplied him with food.

After three years Benedict relinquished his life as a hermit, as the people and monks of the region induced him to become the abbot of a monastery. Later he founded twelve monasteries along the hills of Subiaco. His fame spread abroad, and patricians and senators from Rome entrusted their young sons to his care. Meanwhile, as documented by Gregory the Great, Benedict started to perform a variety of wonders.

> *Three monasteries, built on the cliffs of a mountain, have no water on hand. One night Benedict climbs to the top of the mountain, prays, and places three stones there. The following day he tells the monks to go to that place and to dig in the places where the stones lay and water springs forth abundantly.*
> *One day a monk was clearing a piece of land using a long-handled sickle. The blade of the tool flew off and landed in the lake. Benedict goes to the shore of*

the lake. He picks up the wooden handle and places it in the water. At that same moment the blade flies to the surface of the water and reattaches itself to the handle.

These wonders are very different from what might be regarded within the Catholic Church as the usual canon of miracles. Within such a religious tradition, Benedict may be seen to have performed "prodigies" rather than miracles, prodigies similar to those attributed earlier to St Martin of Tours in the Fourth Century in the Roman province of Gaul. Prof. Giardina in his lecture in the 1989 Congress on Psychopathology, Culture and Magic Thought, pointed out that the VIRTUS (Virtue) of the medieval saint is more a performance of traditional techniques for engaging with the supernatural rather than a divine message. As was fairly typical in recounting religious stories at that time, Gregory adopted a narrative style in recounting Benedict's prodigies in a manner easily understood by the common people and likely to evoke their veneration. Indeed, all through medieval times and throughout Europe the religious education offered to all social classes, in particular the lower classes who lacked access to scripture, was by means of stories of the lives of the Saints, frescos, and other tales, often very amusing ones. In the process the Church effected a cultural shift from pagan to religious mythology. After Benedict moved from Subiaco to establish his monastery at Monte Cassino, a high hill located at a crucial point above the central SOUTH/NORTH Italy route, the account of events changes, showing Benedict performing more remarkable wonders than before.

As soon as S. Benedict reaches Mount Cassino (520), he shatters the statue of Apollos, turns over the altar and sets the sacred grove on fire. In their place he erects an oratory in honour of Sant. Martin (316-397). Humanity's ancient foe, the Evil one, manifests himself…but Benedict remains unaffected by the devil.

Among the last of the prodigies quoted by Gregory, the faculty of appearing at will in dreams is also attributed to Benedict.

Benedict sends some monks to Terracina to build a monastery: 'go, and I will follow you and show you the plans'. He does not arrive. He does, however, come to them in a dream and indicates to them his plans for construction.

Benedict died in 547 AD. But Gregory's history of Benedict the Saint does not end there. In the last pages of his book, Gregory reports a healing miracle that happened after Benedict's death. This event is of particular psychiatric interest as it concerns the miraculous healing in his Cave of a mad woman.

A woman having lost all reason wanders aimlessy and tirelessy over the mountains and fields, shouting day and night. One day she stumbles unwittingly into Benedict's cave where she reposes for the night. At daybreak she exits the cave a sane woman.

In this anecdote Gregory attributed to Benedict the holy power of a *disembodied* intervention, i.e. the healing, after his death, of a sufferer who visited the cave in which Benedict had lived.

Notwithstanding his promotion of what he saw as Benedict's supernatural powers, Gregory failed in his efforts to elevate Benedict to the status of an Italian saint revered for his miracles. Even after his nomination as Patron Saint of Europe, nowadays there is no pilgrimage to visit his birthplace, as for other saints. Perhaps, having linked *Ora* (pray) with *Labora* (work), the sacred and the mundane aspects of life, Benedict has not attracted the Italian imagination and devotion as do other thaumaturgic miracle-working saints!

3. The interface between Faith and Science: the Preci Surgical School

Our Congress is being held in a place where the past and the present rub shoulders. We have traversed some of the history of Norcia, and of its most famous son, St Benedict. In the process we have gone back to times and modes of thinking far different from our own. Our own modes of thought have been shaped by the history of ideas and the growth of science, as our forebears have journeyed through the Enlightenment, the Industrial Revolution, the culture shift of Evolutionary thinking, political revolutions and World Wars, to the computerisation and globalisation of our own age. To try to image the early stages of that journey is difficult. However, retaining our historical stance, but moving toward themes which will be addressed and discussed in our Congress, let us now focus on the figure of Benedict as the initiator of the pragmatic Rule of his monastery, a Rule which included dealing with physical healing, and beyond Benedict to this valley's broader contribution to medical history.

Benedict's Rule of *Ora et Labora* (prayer and work), affirmed a community in which both sweat and incense had their place, and the sacred and the mundane were held in balance. This pragmatism contrasted with some other Christian and non-Christian traditions, for which the route to spiritual enlightenment was through asceticism and withdrawal from the demands of the world.

Following the fall of the Roman Empire, and the consequent decline of Roman medicine, the Benedictine monacus-medicus became, through the middle ages, a cornerstone of the practice of the healing arts, in the protected environment of monastic life. The monacus-medicus operated as a helping professional as the Rule 'Ora et Labora' clearly indicates that healing illness had priority above any other activity: *Cura infirmorum ante omnia et super omnia adhibenda est*".

Also, from an architectural perspective, the Benedictine monastery was structured to allow both for the liturgical life of the community and the therapy of sick patients. Parallel to the chapel, in all monasteries there was a *claustrum infirmorum i.e.* the infirmary, with rooms for bathing and to perform phlebotomy, and a medical library under the guidance of a MONACUS INFIRMARIUS who later was named MEDICUS. Following the traditions of Roman medicine the monacus-medicus diagnosed illness and performed various interventions based on knowledge of medicinal herbs and basic surgery.

Moving beyond Benedict, around eight hundred years ago the valley where we now are was the site of an important event in medical history. The synergy between the monacus medicus in the Saint Eutizio monastery and the local pork butcher, renowned for his skill with the knife, became the basis for one of the first surgical schools in Italy. The first documentation of the surgical school of Preci dates from around 1200. Earlier, the Council of Tours, in 1163, following the cry "Church Abhor Bload - Ecclesia Abhorret Sanguine", and the Concilio Lateranense of 1215, declared "the monk is not to perform any surgical act connected with cauterization or incision of the body of the patient", thus separating the spiritual from the surgical.

Such direction to the monacus-medicus left the butcher turned surgeon to act openly as a medical practitioner. Thus the SANITAS CORPORIS (bodily wellbeing) was transferred into lay hands, while the medicus monacus became a specialist only of SALUS ANIMAE (the wellbeing of the soul).

The side-effect of the Vatican banning the monacus from dealing with physical illness was that the itinerant surgeons were then free to organize themselves into a proper School. The peak of the Preci Surgical School, and its full international recognition, came in 1468 when in Vienna Queen Eleonora, wife of Federick III, underwent a successful cataract operation, performed by Sigismondo Caraci di Preci. The Preci school also became known for surgery to remove bladder stones through peritoneal incision. The Seventeenth Century archives of the Santo Spirito Hospital in Rome document that bladder litotomy as performed in Norcia was mandatory in the hospitals of Rome "because the medicus coming from Norcia learn from their childhood the practice of surgically intervening in the urinary calcolosis".

As a final comment on their prowess and reputation in earlier times, the surgeons of Norcia were famous as "castratori nursini". Skilled in castration, they were invited by the Vatican to contribute their expertise to enhancement of the singing of the chorus of "voci bianche" of San Pietro Chapel.

4. Conclusion

The interest we all have in transcultural issues has prompted us to share with you some of the rich cultural history of this region. Our journey through the past has also been prompted by the belief that the birthplace of St Benedict is a singularly appropriate place to reflect on issues at the interface between religion, culture and science.

Our focus on surgery in this valley has been one of necessity, as there is no history of psychiatry till recent times. Earlier, manifest mental illness was dealt with here, as elsewhere, in various and sometimes brutal ways, through magical practices, acts of devotion to God, even burning or torture of those deemed to be mad.

As psychiatrists, mental health professionals, and students of culture, we may find ourselves in a strange historical and practical dilemma, being seen as both the medicus of the psyche and the medicus of the body. The title of this congress highlights our interest in both the biological and the psycho-cultural, the "cultural brain" as a product of the interaction between biology and culture. We live in an age where the secular life of modern societies is often juxtaposed with the religious convictions and practices of differing religious traditions. The challenge of understanding the cultural roots of conflict and confrontation is a critical challenge for cultural psychiatry, and one which will no doubt exercise

us over the next few days.

Today's conflict prone era has perhaps more in common with that of Benedict than we would wish. Our own community of interest here in this Congress, with its diversity of cultural and academic backgrounds, shares a common commitment to the health and well being of all. As in previous Congresses, we will engage once more with the challenge of reaching across cultures, and the divisions of our human condition, to understand better the forces for healing which can be brought to bear on the challenges of our own age. So on that note, an invitation to scholarly dialogue, we will conclude this introductory address, wishing you all a most profitable and enjoyable Congress.

SECOND DAY - September 28 (Monday)

Key Lecture

Cultural Brain and Living Societies under the Influence of Theology and Medical Science

G. Bartocci (*Italy*)

The aim of this key lecture is to underscore the epistemological centrality of Cultural Psychiatry as the branch of Human Science capable of understanding and acting upon the complex cultural events occurring in the course of the this 21st Century.

The scientific programme of this Congress covers a vast epistemological area within the scope of the mission of the WACP. Thanks to the collaboration of the Society for the Study of Psychiatry and Culture, of the WPA Transcultural Psychiatry Section and of numerous local scientific societies or single participants, the World Congresses of Cultural Psychiatry organized by the WACP have now turned into a three-yearly milestone for scholars in psychiatry who take these meetings as the occasion in which to review their work and develop their future research strategies. The fact that, in our Congresses, scientific rigour is interspersed with imagination, creativity, real friendship and humour, makes these meetings all the more enjoyable.

Therefore, having verified the solidity of our launching pad, I now feel authorized to devote this Key Lecture to the study of *the different forms of influence exercised by Theology and Medical Science on shaping Individual Mental Health.*

I would like to point out to the audience that my attempt at re-focusing your attention on the study of the interface between Theology and Medical science or if you prefer, on the Science-Faith debate, is not aimed at re-opening a theoretical/philosophical survey on the greater systems of the world. My focus is clinical and not philosophical.

GALILEO: Yes! And that the whole, vast universe with all stars does not revolve round our tiny earth - as must be obvious to everyone.
SAGREDO: So that there are only stars there! - And where then is God?
GALILEO: What do you mean?
SAGREDO: God! Where is God?
Bertolt Brecht "The Life of Galileo" (1937)

As matter of fact, now the major novelties in the Science-Faith debate are no longer only driven by the study of astronomy but rather by two relatively new scientific disciplines: neuroscience and cultural psychiatry.

Neuroscience, because it holds the record for having first included the human soul among the subjects of study of biological sciences.

Cultural Psychiatry, because it is the discipline that is best fitted to go deeper into the study of the wide variety of religious experiences.

The title of this Congress ***Cultural Brain and Living Societies*** was conceived with the aim of providing as wide an epistemological outlook as possible in highlighting the major role played by neurosciences in attributing to *culture* a *physically plasmatic power over the brain.*

Within the dyad "**Cultural Brain and Living Societies**" I have here incorporated the theme of "**The Influence of Theology and Medical Science**", in order to stress that the epistemological area of competence of cultural psychiatry also includes the task of re-introducing the notion of the soul within the area of knowledge searchable with our methods of study.

As for the influence of neuroscience on the theory of the mind, it was the publication of *The astonishing hypothesis: The Scientific Search for the Soul* (1995) by the Nobel Laureate Francis Crick that marked the point of non-return in acknowledging the soul as a special state of consciousness.

Ever since this book was published, expunging the soul of its theological origin has become the "natural" outcome of a method of investigation that was further illustrated by Koch in 2004, in *The Quest for Consciousness.*

Koch replaced the dogma of a "*creation of something out of nothing*", or of the "*belief that at the heart of consciousness lies a transcendent and immortal soul*" with *"the birth of consciousness"* merely

considered as one among the *"brute facts"* of neural activity.

On our part, scientific contributions made by transcultural scholars have already succeeded in defusing the taboo of studying sacred thought. [See the large number of papers by Raymond Prince on religious experience and endorphins, the secular approach taken by Armando Favazza in his *Psychobible*, the interbreeding between anthropology and Psychiatry in *Religion Agency Restitution* by Roland Littlewood, the panorama of different Authors in *Psychiatry and Religion* by James Boehnlein and the papers by Simon Dein and myself, published in the Special Issue of Transcultural Psychiatry, dedicated to *Spirituality and Religion,* 2005 (thanks to Laurence J. Kirmayer), as well as the Chapter *Religion and mental health* in Kamaldeep Bhui & Dinesh Bhugra's textbook *Culture and Mental Health* (2007), as well as the writings of many more Authors]. So, the question to be addressed now is the following:

How can we, cultural psychiatrists, contribute in promoting and enhancing this re-sprouting of Renaissance thinking?

How can convert into a cultural reality the possibility of recognizing that the psyche is not subordinated to a locus of extra-mundane control?

The statements made by neuroscientists are particularly focused on indicating general culture, and not religious culture, as the evolutionary prerogative of the human species: *"The reason for which the human species dominates the planet while gorillas are in danger of extinction lies in the 5% of DNA that is exclusive to man […] and should instead be sought in our capacity to accumulate and transmit culture…"* (M. Ridley, 2003. p. 299); *"The social climate is but only one of the forms of cultural transformation"* (Richerson & Boyd, 2004, p. 43); *"Continuous interaction with the people who surround us, through verbal and non-verbal communication, materially change the brain, thus contributing to consolidating this change on a day-by-day basis"* (Boncinelli, 2009).

My insistence on calling upon the scholars of cultural psychiatry to come into play is not only motivated by the fact that, from my Roman observatory, I am led to believe that the forces aimed at promoting the movement of spiritual psychiatry greatly outnumber those pushing for a secular *credo* in psychiatry.

It is the very admission of neuroscientists themselves that the science capable of understanding intentional phenomena is the science of the psyche and not the science of neurons, that is calling us into action.

To speak in terms of quanta and qualia, of synaptic dyssynchrony, of fill-in, of the migration of neurons, of "pruning" old neural networks in order to make room for new ones, is certainly innovative. However, if we keep these innovations locked up within the realm of neuroscience, we will not add any meaning on how internal images are shaped due to the fact that the mind's way of thinking is "*always mediated by culture in the sense of the ways of life, language, ritual practices, beliefs and aesthetics of a group, community, or society"* (Hinton et al., 2008).

In order to put into better focus the slow-paced transition that led to substantial modifications in the workings of the mind due to different ways of life, I find it fitting to paraphrase what Osterreich said in 1930, when he tried to analyse the experience of evil possession: *"Much more probably [in traditional populations] it was rather the conviction of being possessed which brought about a real division of the mind, whereas in the divisions observed today the relation is reversed:* ***first there arises a genuine division of the inner life, and then the individual declares himself 'dual"***. (Oesterreich, 1930)

MY CONCERN as to the possible destiny of the dual mind arises from the observation that, in the Western World, we are witnessing a pandemia of dissociative phenomena.

I am not only referring to the well-known International Pilot Study performed by the WHO in the 1970s which highlighted the worse outcome of schizophreniform pathologies in Westernized populations compared to traditional populations, which showed a prevalence of acute, transient psychogenic reactions.

The uptrend in Multiple Personality Disorders in the Western Cultures that are overly consecrated to the dual mind should spur us to stop toying with the conviction that the body/spirit duality is a "natural" divine gift, while it is more rigorous for a scientist to consider the body/spirit split as being reinforced by the continuous double register imposed by counter-opposing theological and positivistic conceptions of the world.

Conclusion

The WACP, as a free-standing international Association – not subjected to political conditioning or pressure from pharmaceutical companies – is at the forefront in its capacity to achieve a number of objectives ranging from the performance of our primary clinical tasks to pioneering theoretical horizons.

I hope that WACP members will not miss the historical opportunity that is offered to us by the bio-psycho-cultural Neo-Humanism to prove

capable of investigating the points of friction between Theology and Medical Sciences without being intimidated by the possibility of getting burnt in the research process.

In the future, we will perhaps never again be able to take for granted the publication of a courageous paper like: *Overtures of Paradise: Night Dreams and Islamic Militancy* (Iain Edgar, in *Curare*, 2008) or hosting a lecture like Littlewood's *Did Christianity Cause Schizophrenia?* in a Congress held precisely in the cradle of Christianity.

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Plenary Session (P-1)
Cultural Psychiatry: The State of the Art
Chair: W.S. Tseng (*USA*)

The Early History of Cultural Psychiatry
W. Jilek (*Canada*)

The early history of cultural psychiatry from the 1800s to 1971 is outlined as evolving under the influence of prevailing contemporary tendencies, represented by the main authors and actors:

1) 19th century focus on civilization and mental health
2) The dawn of comparative cultural psychiatry (ca.1890 - 1925)
3) The influence of psychoanalytic theories (ca.1913)
4) Psychopathology labelling of peoples and cultures (ca.1900 - 1950s)
5) Cultural relativism of mental disorders (since 1930s)
6) The establishment of cultural/transcultural psychiatry as academic discipline and organized endeavour (1956 - 1971).

Current Trends in Cultural Psychiatry: From Margins to Mainstream
L.J. Kirmayer (*Canada*)

In the last few decades, cultural psychiatry has undergone a transformation from focusing on exotic conditions and culturally distant 'others' to addressing core issues of everyday clinical practice. This shift has been driven by several factors: global changes in patterns of migration that have increased diversity in many societies; changing demography within the profession that has demanded attention to culture within the mainstream; the insights of medical anthropology that have pointed out some of the cultural assumptions and values of conventional psychiatric theory and practice; and a 'postcolonial' political context in which there is increasing recognition of the validity of diverse viewpoints. Research in cultural psychiatry is addressing basic questions with relevance for the future of psychiatry in general: What role does culture play in the mechanisms of psychopathology and the processes of healing, recovery and resilience? How does the brain enable us to acquire culture and how, in turn, does culture reconfigure the brain through developmental processes across the lifespan? How is culture itself being transformed in the face of globalization and the growing influence of electronic media and communications? How can mental health services and interventions best respond to cultural diversity in the context of different societies and health care systems? What relevance do the perspectives of cultural psychiatry have for the larger geopolitical problems of our time? Cultural psychiatry is having increasing impact on psychiatric nosology, mental health policy, training and service development. This presentation will survey recent work in each of these areas to map the current terrain of cultural psychiatry in theory, research and practice.

Contributions of Cultural Psychiatry to International Psychiatry
J. Westermeyer (*USA*)

Goal consists of identifying concepts, strategies, and clinical methods that cultural psychiatry has been and will be contributing to psychiatry around the world.

Method consisted of (1) reviewing topics at an international meeting, (2) efforts made by the World Health Organization to foster mental health care around the world, (3) submissions to mental health and addiction journals, and (4) discussions and observations of medical students, residents, and practicing psychiatrists from various parts of the world.

Findings consist of themes and approaches that students of socio-cultural psychiatry have made in the following areas:

Theory: sociocultural resources and pathogens (social networks, actual versus ideal norms, idioms of distress).

Mental Health Services: externalizing versus internalizing disorders (e.g., alcoholism services), effects of racism/sexism/ageism on mental health and disorder (depression-somatization in oppressed women, youthful suicide and homicide in oppressed men).

Clinical Practice: cross-cultural services (use of translators, cultural transference-countertransference), acquired vs. constitutional-genetic disorders (PTSD, acquired MR, mTBI), over-diagnosis of Schizophrenia.

Discussion will address issues apt to increase in importance

- Absence of, but movement toward an international psychiatry
- Bolstering sociocultural resources while eliminating (or ameliorating) sociocultural pathogens
- Inter-relationships between diagnostic schemata and pharmacotherapy (e.g., treatment of symptoms versus treatment of disorders, undue influence of the pharmaceutical industry, growing ascendency of "Dr. Feelgood" ideology)
- The growing disconnect between most psychiatric disorder (chronic and/or recurrent) and much system-driven treatment (brief, hurried, non-continuous).

Plenary Session (P-2)

SCIENCE AND FAITH

Cultural Psychiatry and the Study of Spirituality

Chair: R. Littlewood (*UK*); Co-chair: A. Favazza (*USA*)

The Postmoderrn Sentiment of Deity and Religiosity. Observations

G.G. Rovera (*Italy*)

A) Even in this day and age, spiritual and religious dimensions are still aspects of the human existence with regard to the considerably complex nature of epistemological, psychiatric and anthropological (in reference to religious background) perspectives, and also because of the specific originality of ideo-affective and value-related areas concerning the spiritual and religious dimensions regarding devotion for a superior being (the deity) with which one implicitly and/or explicitly believes one should conform. Although spiritual and religious dimensions have cultural roots that can be traced in different ways (feelings of guilt and inadequacy, altered states of consciousness, grandiosity, depression, etc.), they often present imponderable aspects with regard to a scientific methodological approach.

What is the purpose of my life? Is there life after death? Why is there evil in this world? Why me? Why now? Questions like these not only pervade all areas of human life, but they also evoke extremely diverse religious beliefs.

B) In traditional cultures, and also according to the positivistic paradigm of western "modernity", the faith of believers could often manifest as ritual practices and ceremonial occasions. These can be placed in a hierarchic setting: religious convictions in a postmodern society would be characterised by a kind of pseudo-independence of the individual and by an often inauthentic rationalistic autonomy, in which rules, principals, thoughts and life choices would disconnect from the reference to the deity, religious beliefs and pre-established guarantees of the Transcendent.

In these contexts, oceanic feeling, which would be at the root of the primitive ego and related to religious feeling, may appear as a simple abstraction both in terms of the model of neurosciences, and also in reference to the attachment theories and psychology of religion. From a reductionist perspective, there are actually different dimensions that characterise the religious experience.

C) With regard to postmodern religiosity, the dominant New Age theory specifies acknowledgment of the prevalence of intuition over reason. From this point of view, it is thought that each individual is capable of forming (creating) an image of the deity which differs from those of others.

As to the psychology of religions, we should remember amongst other things:

a) The mechanistic assumptions which are accepted for the most part by the current guiding principles of neurosciences in which the final goal is missing;

b) On the other hand, the atheistic definitions. These are missing the natural causal foundation because the Deity can not be scientifically proven in that it is a dogma of the faith, even though we tend nowadays to give it characteristics of plausibility.

So with the New Age there is a tendency to encompass "everything" without excluding the interior world, even when the limits of all scientific discoveries have been surpassed. This would constitute a radical repudiation of the modern scientific world beyond the hybris of the technological era.

However the price to pay would be to establish an immanent god, seen as a reflection of nature. This would develop methods of "expansion of the conscious states" and one would pass beyond the physical world by way of the astral and the spiritual.

We can recognise paths which in some cases are worrying and rather sectarian (this could also involve psychotherapeutic approaches).

In this light, the New Age seems to be fundamentally gnostic and panentheistic, and often reaches syncretistic individualism.

Behind and inside this new, cultural, spiritual and religious situation, we perceive the need to exorcise an individual's internal fears.

D) Comparative Individual Psychology (C.I.P.) proceeds differently from the previous observations. In actual fact, an individual's deep (and unconscious) intentionality is to place his or herself in the world as if there were a pre-established task and goal. Although this task or goal is unrealisable, it would indicate (fictitiously or through a Husserlian epoche) the path or direction to take. This is because humans are driven to continually fight for self-preservation; this would include the teleonomic and negentropic tendency. When faced with the inevitability of death, the individual would express his or her tendency to strive for a deity, whose task would be to show them the way to their goal, to the plausible completion of the eternal movement of the existential journey.

By striving for the supreme power and for the "as if", humans tend towards a kind of deity, and this is in relation to the constant pervasive feeling of inferiority.

The ideal goal (faith?) could appear as God (and on the level of finitude and guilt, this could be the same as social feeling and/or interest). The love of God and the love of one's fellowmen (charity?) would nevertheless express the individual's supreme desire and incessant yearning for a "promise of completeness" (hope?).

E) The sense of the divine stays with the individual (almost like a neuroscientific qualia) in so far as it would represent a Jaspersian concrete enigma as opposed to the Adlerian idea of perfection, greatness and superiority.

The desire to be in God, to hear his call, and to have an exclusive relationship with him – essentially tending towards the deity – would constitute an instance, an intentional and partially unconscious goal, rather than a drive or an instinct. This desire would therefore be geared towards soft finalism rather than towards a drive derivable from deterministic energy.

The idea of God according to C.I.P. (see the correspondence between Adler and Jan, the priest from Berlin) could be a modern take on a human's striving for greatness and perfection. It may also represent a kind of consecration of the individual and of society towards a future-orientated goal (or projected into infinity?); in the present and in the finite, this would lend meaning to a course toward the deity and the Absolute.

F) It is appropriate to remember that there is still no scientific explanation for the adoration of a fetish, phallus, lizard, etc. in traditional cultures. Nevertheless the fact remains that a primitive concept of the universe has favoured community life and social feeling and/or interest. Just like in days gone by, religious fervour still seems to often grant protection to the community and its subculture. This would also confer a sacred union of man towards God, which can be seen in every believer.

The gradual strengthening of religious feeling and of the love for one's fellowmen could also be derived from the primary tender links with the maternal figure, as is also hypothesized by the attachment theories.

An individual's tendency towards unification with the deity would also lend credence to redemption and to the deliverance from all evil (the Adam and Eve complex) as well as to him or her striving to continue to "exist" after death.

Striving for the Absolute and the ensuing religious feeling could also be seen as the cultural heritage of evolution and as a result of the "ongoing struggle" (soft finalism).

G) The truth is that in the past, and even now, numerous communities fought between themselves for the right to pit one religion (seen as real) against another religion (seen as false). This wouldn't depend so much on the assumptions on which one religious feeling rather than another is based. It would depend more on the contrast emerging from the different types of organisation of power that the so-called positive religions have conferred upon themselves with their dogmatic, theoretical, ethical-confessional and political-social criteria.

Looking back through history, we see that this has often led to situations of abuse and ill-treatment.

A plural, rather than merely pluralistic, approach with appropriate references to cultural psychiatry could favour an interreligious dialogue.

Psychiatry and the Spiritual Life

A. Favazza (*USA*)

Religion, religiosity, and spirituality have overlapping dimensions but are not interchangeable concepts. Some religious values are broad but many are specific, narrow, and dogmatic. Spiritual values are broad e.g., acceptance of the sacredness of nature and of all human experience; knowledge that ultimate fulfilment cannot be found in material things, etc. Ordinary spirituality differs from the intense, unique, joyfully bewildering, usually brief but sometimes transformative experience of Spirituality with its feelings of special connectedness with a supernatural being or with the universe or with nature.

Ordinary spirituality revolves around positive feelings such as love, hope, joy, forgiveness, faith, gratitude, idealism, and altruism. In supportive psychotherapy, even during brief clinical medication check-up encounters, the psychiatrist should advise patients to lead a spiritual life although the word "spiritual" may never be used. Examples of spiritual advice that might be given to patients include accept the responsibilities of parenthood; care for your pets; do volunteer work; care for the integrity of one's body (diet, exercise), etc. If religion was once important to patients, or if patients express a desire to join a religion, help them to find a congenial and accepting church, mosque, synagogue, or temple.

No one is perfect, and a person does not have to be a saint to lead a spiritual life. When envy, divorce, marital infidelity, drunkenness and other problems arise, the psychiatrist's role is to minimize their negative effect and to provide advice to help patients get back on track.

Religion and spirituality have a dark side that should be kept in mind e.g., persons who believe too strongly in a cause or in their own righteousness may become negative towards and intolerant of others; cult leaders are experts in twisting religion and spirituality to the ultimate detriment of their followers; usually noble feelings such as patriotism or love of god can be manipulated into the "negative spirituality" of genocide, suicide bombing, and spousal abuse

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Did Christianity Cause Schizophrenia? Monotheism, Conversion and Theory of Mind

R. Littlewood (*UK*)

There is considerable evidence, historically and culturally, that schizophrenia is a fairly recent and Western psychosis, modified from a shorter-lived, better prognosis illness with more confusional and florid features. The argument here, relying on recent work by Louis Sass, is that this has been facilitated by the sort of reflexive self-consciousness typical of modern western industrialised societies; arguing that every theology also carries a psychology, the paper examines how an ideology of an omniscient God, of an individual self which has to be scrutinised, a downplaying of the empirical physical world and the reflexive consciousness of conversion are all significant.

Using data from Origen, Tertullian, Augustine, G.Fox, as well as Plotinus and M.Aurelius, and others, it argues that Christianity set in train an individual psychology later amplified by Islam, literacy, printing, the Reformation, the rise of the secular autobiography, the novel, industrialisation and telecommunications. The role of theology as an 'indigenous psychology' is discussed in the context of William James' religious ontology.

Religion and Schizophrenia

S. Dein (*UK*)

Historically religion and madness have been held to be closely related. Extreme religious behaviour is often labelled as madness. There has been a longterm debate on the mental health of the shaman among social anthropologists, some of whom have even argued that all religious cognition is psychotic (eg, La Barre 1970). There are a number of empirical associations between religion and schizophrenia. Patients suffering with schizophrenia demonstrate high prevalences of religious delusions. In a recent UK study 28% of in patients with schizophrenia reported religious delusions (Siddle 2002). Religious and paranormal preoccupations are common in those individuals with schizotypy. The phenomenological features of both schizophrenia and various religious experiences demonstrate considerable overlap. Pentecostal Christians experience God's voice coming from outside their heads and some experience God's thoughts entering their minds . Finally , members of New Religious Movements such as the Hare Krishna score highly on delusional scales . To what extent is this association intrinsic?

Individuals with schizophrenia frequently resort to religious forms of coping including the use of prayer, the support of the religious community and reading liturgy. Religious coping may alleviate some of the distressing symptoms of schizophrenia such as hallucinations and there is some evidence that higher religiosity may improve the prognosis of those suffering with schizophrenia (Mohr, 2006).

We propose that schizophrenia and religious cognition employ the same mental modules: agency detection and theory of mind. There are similarities and differences between assumptions of ultrahuman agents with omniscient minds and certain 'pathological' forms of thinking in schizophrenia: thought insertion, withdrawal and broadcasting, and delusions of reference. In everyday religious cognition agency detection and theory of mind modules function "normally", whereas in schizophrenia both modules are impaired. Religion and schizophrenia may have similar evolutionary origins. In both religious experience and schizophrenia there is a breakdown of boundaries between the self and the outside world.

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Plenary Session (P-3)

Immigration and Acculturative Stress in Era of Fear and Terrorism

Chair: R. Wintrob (*USA*); Cochair: M. Kastrup (*Denmark*)

Yearning to Breathe Free. Immigration to the USA since 9/11

R. Wintrob (*USA*)

Legal immigration to the USA has been increasing steadily in each decade since the 1970s. There has been strong public support for an immigration policy that welcomes legal immigrants, as well as refugees from war-torn regions of the world. That 'open-door' policy has been challenged, but not reversed, since the terrorist attacks of 9/11/2001.
Between 2000 and 2005 the numbers of legal immigrants to the USA has risen from 9.8% to 12.4% of the total US population. However, the number of refugees and asylum seekers has been declining since 2000.

The US Congress has deadlocked on efforts to revise immigration policy since 9/11. Public sentiment has clearly favored secure borders and responded to fears of terrorism. Immigrants living legally in the USA have experienced mounting anxiety about discrimination and fear of being mistaken for illegal immigrants and deported.
These fears and experiences of discrimination since 9/11 have undermined the sense of security of large numbers of immigrants, and increased the incidence of psychiatric distress symptoms among them.
This presentation reviews data about these issues and discusses their implications for immigration policy and for the provision of mental health services for immigrants and refugees in the USA.

Social, Cultural and Political Aspects of Migrant Mental Health in Switzerland

M.G. Weiss (*Switzerland*)

Tensions of compassion and conservatism, the balance of benefits and costs, and the continuity and change of traditional local cultures are vigorously debated features of immigration policy throughout the world. Questions of dangerousness further complicate and often cloud such debates. In Switzerland, longstanding migration policies may deny Swiss-born children of immigrants full social acceptance as citizens. In a recent political election, a campaign poster depicting 3 white sheep kicking out a black sheep sparked a national controversy, protest, and confrontation that became a focus of international attention. With a total population of 7.57 million in 2005, 1.66 million (21.9%) were classified as foreign residents, and the annual immigration was 99,091. The largest number of foreign residents was from Italy (303,455) and other European countries (1,412,987 from all of Europe). Turkey is the leading non-European country of origin, and it ranks as fifth most common national origin of foreign residents (78,711). Foreign residents now also include asylum seekers from conflicted areas (e.g., 46,773 from Bosnia and Herzegovina). This changing character of migration has renewed questions that were resolving from previous waves from neighbouring countries. Mental health policy for the migrant population has been concerned with access to psychiatric services and issues of adjustment to an ambivalent reception that grows more hostile in an expedient political climate. This paper considers priorities for mental health policy, services, and research with reference to mutually changing perceptions and cultural views of the other in the immigrant-host relationship.

Immigration and Acculturation in The Netherlands, in the Light of Terrorism

H. Rohlof (*The Netherlands*)

The Netherlands is not an official immigration country: immigration is not encouraged and there are no official quota for immigration. Yet, there are two groups who immigrated into the country during the nineties: families of former working migrants from Turkey and Morocco and refugees from Eastern Europe, Africa and Asia. The numbers of immigrating individuals increased because of possibilities of family reunion and the wars in Bosnia and other places, and because of growing possibilities to travel.
After the acts of terrorism political right wing parties started a public debate putting immigration as a danger for the Western democracy. This debate turned out to be more extreme in the latest years. This had effect on immigration policy and numbers: policy became stricter, numbers decreased. After the murder on Theo van Gogh we performed a study on the effects of this happening on patients in mental health care. The public paranoia and mistrust in different population groups was clear. A new target of mental health care is to help migrant patients find their way in a multicultural society where there is a growing animosity between population groups. Clinical implications of this attitude will be discussed.

The Era Of Terrorism: Ethical Dilemmas and Educational Needs

M. Kastrup (*Denmark*)

With the strong focus on terrorism in recent years there is an increasing concern that fundamental human rights may be violated in the interest to combat acts of terrorism. It is in particular in situations of interrogations that persons may be exposed to various kinds of interrogation techniques that go against international conventions.
According to the UN Convention of 1984 against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Article 10, states having signed the Convention shall ensure that education and information regarding the prohibition of torture are included in the training of e.g. medical personnel who may be involved in the custody, or treatment of individuals deprived of their liberty. Unfortunatey, few countries enforce this, implying that few psychiatrists receive any such education and thus have little knowledge on the issue of organised violence in relation to terrorism.
Knowledge about the mental health consequences of state perpetrated violence, including torture is of clear clinical relevance for psychiatrists worldwide as a significant proportion of e.g. refugees and migrants have experiences of war, strife, persecution and torture and a large proportion of the worlds population live in countries that condone torture.
The paper will outline the psychiatric symptomatology following exposure to state perpetrated violence and torture, preventive considerations as well as ethical dilemmas and educational needs for the psychiatric profession.

Standard Symposium (SS-I-1)
Culture and Schizophrenia

Chair: T. Stompe (*Austria*); CoChair: G. Ortwein-Swoboda (*Austria*)

The impact of culture, gender and age on the contents of delusions in schizophrenia

S. Bauer (*Austria*), M. Bauer (*Austria*), H.R. Chaudhry (*Pakistan*), S. Idemudia (*Austria/Nigeria*), H. Karakula (*Austria*), P. Rudalevičienė (*Lithuania/Austria*), S. Gschaider (*Austria*), T. Stompe (*Austria*)

Objectives

To explore the impact of culture, gender and age on the contents of delusions in patients with schizophrenia.

Methods

The contents of delusions in patients diagnosed with schizophrenia according DSM-IV from Austria, Lithuania, Poland, Georgia, Ghana, Nigeria, and Pakistan (n=1,080) were examined by means of SCID1 and a semi-structured questionnaire on psychotic symptoms (FPS).

Results

Delusions of persecution and grandeur were the two most prevalent themes everywhere. In contrast delusions of guilt and religious delusions occurred more frequently in Christian than in Islamic countries. Other delusional contents like apocalypse, descent, jealousy, being loved were sparsely reported.

Independent of the culture of origin, women suffered more often from delusions of guilt and being loved. In most countries religious delusions were significantly more often reported by younger subjects. Hypochondriac delusions predominantly occur after a longer course of illness. An early onset of disease was often associated with delusions of apocalypse and religious delusions.

Conclusion

Culture, gender and age seem to have an impact on the prevalence of certain contents of delusions. The way these factors may influence the shape of delusions will be discussed.

Culture, Content of Delusions and Delusional Perception

G. Ortwein-Swoboda (*Austria*)

In the meantime the strong cultural influence on the content of delusions is a well established knowledge. However, this influence varies among the themes. Schneider's "first rank symptoms" show an unequal distribution among different cultures, too. But, as one might expect, the presence of first rank symptom also varies with the specific subtype and the course of schizophrenia. In particular, delusional perceptions seem to be a characteristic symptom of the early stages of schizophrenia. Analyzing the data of 1,080 patients with schizophrenia of the 7-country International Study on Psychotic Symptoms, this presentation tries to demonstrate the complex interaction between cultural patterns and certain principles of the course of schizophrenia.

How to distinguish between delusions and (sub)cultural believes?

T. Stompe (*Austria*)

Differentiating between "strange" but normal cultural believes and contents of delusions is still an open challenge. Most of the established definitions of delusions are not qualified to solve this problem.

During the last hundred years three different major concepts of delusions have been developed:

1. Delusions are disturbances of the external and internal relationships between the individual and the surrounding world (e.g. Binswanger, Blankenburg)
2. Delusions are false believes (e.g. Jaspers, DSM-IV)
3. Delusions are wrong logical and/or pragmatic judgments (e.g. Kraepelin, Berner, Spitzer)

The implications of these concepts for transcultural psychiatry will be discussed. Additionally, a new definition of delusions, suited for culture comparison studies, will be introduced. It is based on analytic philosophy ("philosophy of mind").

Standard Symposium (SS-I-2)

Psychopharmacotherapy of the 21st Century – Cultural Aspects

Chair: A. Semke (*Russia*); Cochair: T. Shushpanova (*Russia*)

New Approaches to Therapy of Patients with Psychosomatic and Anxious-Depressive Disorder in Siberia

G. Semke (*Russia*)

Anxious-depressive disorders are able to aggravate course of cardiovascular pathology in association with disturbance of functional state of hypothalamic-pituitary-adrenal and sympatho-adrenal systems. Objective of our investigation was to study relationships between dynamic of anxious-depressive disorders and indices of circadian profile of arterial pressure (AP) against the background of monotherapy with coacsil.

34 patients have been examined (24 female and 10 male, mean age - 46,4±7,2 years) with arterial hypertension (AH) stage I, associated with anxious-depressive disorders. Circadian monitoring of AP was conducted and mean systolic (SAP) and diastolic (DAP), AH time index (TI), AP variability at various time of the day were analysed before treatment and after 3 months of therapy with coacsil at daily dose 37,5 mg.

Heightening of the level of anxiety was accompanied by increase of diurnal SAP (R=0,61, p=0,02) and DAP (R=0,57, p=0,03), TI of diurnal DAP (R=0,58, p=0,03), TI of nocturnal SAP (R=0,56, p=0,03) and DAP (R=0,61, p=0,02) and decrease of degree of nocturnal lowering of DAP (R= -0,64, p=0,013). Increase of baseline depression promoted heightening of variability of diurnal SAP (R=0,72, p=0,015) and DAP (R=0,86, p=0,001). Monotherapy with coacsil resulted in reliable reduction of severity of anxious-depressive disorders what was accompanied by significant lowering of magnitudes of TI of AP during a day. Degree of lowering of anxiety and depression correlated with magnitudes of nocturnal DAP (R= -0.86, p=0,001) and TI of diurnal SAP (R= - 0,72, p=0,018 as well as – with dynamic of TI of nocturnal SAP (R=0,81, p=0,005) and DAP (R=0,64, p=0,04).

Presence of anxiety and depression in patients with AH results in deterioration of indices of circadian profile of AP. Inclusion of coacsil into complex therapy of such patients promotes heightening the efficacy of hypotensive treatment.

Clinical-Biological Features of Drug Response in Patients from Various Ethnic Groups with Alcohol Addiction in Siberia

T. Shushpanova (*Russia*)

Individual human sensibility to psychoactive substances (PAS) effects defined as a possibility to adequate adaptation reactions, which controlled by genetic and some social factors. For example, there are the homeostasis control system and the antioxidant systems, too.

In association with multi-dimensional impact of ethanol on pharmacodynamic and pharmacokinetic of a broad range of drugs and for rational use of pharmacotherapy in alcoholic patients it is very important to evaluate state of pharmaco-metabolizing function of liver which is involved into interaction of ethanol and psychotropic drugs.

It is known that optimizing of disrupted homeostasis during acute or chronic psychoactive substances being provided with specific and nonspecific mechanisms as such as microsomal cytochrome - P 450, dehydrogenases and others.

The analysis of some literature dates and own clinical-biochemical investigations results (under the observation there were 168 patients, men only from 27 to 62 of age with different levels of alcohol abuse) shown that activity of microsomal cytochrome - P 450 is close connected with the such phenomenon as individual tolerance to alcohol, rate of alcohol dependence forming and alcohol induced splanchnesthetic complications character.

Sensitization of Cytochrome P - 450 system to action of psychoactive substances with inductive properties under influence of alcohol can become a significant problem of psychopharmacotherapy. We investigated effect of long-term dozing of original anticonvulsant Galodif® on activity of the liver cytochrome P - 450 system of alcoholics from two different ethnic groups (Tatar and Russian) by means of antipyrine test.

M-chlor-benzhydrylurea (m-CL-BHU) - Galodif® is a novel, highly efficient anticonvulsant from series of linear urea derivatives.

Galodif (meta-chlorbenzhydrilurea) has been synthesized at scientific laboratory of drug synthesis of Tomsk Polytechnic University and experimentally studied at Pharmacology Chair of Siberian State Medical University in the process of search for highly effective anticonvulsants among linear and cyclic derivatives of urea.

Results of clinical trails have shown reliably high activity of Galodif possessing broad spectrum of antiepileptic action. Galodif appeared to be mostly effective regarding grand seizures, focal with simple symptoms, temporal and secondarily generalized seizures. Preparation can prevent development of delirium alcoholicum and stop it within short terms. Thus, Galodif represents by itself highly effective, not toxic, well tolerated antiepileptic preparation with useful additional kinds of pharmacological activity.

Therapy of complicated forms of alcoholism as a whole represents great difficulties because formed organic brain deficiency constrains application of psychotropic preparations in recommended for achievement of the therapeutic effect doses.

It is known, evaluation of relationships "pharmacokinetics – pharmacodynamics" for anticonvulsants is highly useful. It has been suggested, drug effects correlate better with drug concentrations in "action biophase", than concentration in blood plasma. Sensitization of cytochrome P - 450 system to action of substances with inductive properties under influence of alcohol can become a significant problem of psychopharmacotherapy, especially for patients from some ethnic groups, including Tatars.

We investigated effect of long-term of original anticonvulsant Galodif® on activity of the liver cytochrome P - 450 system of alcoholics from two different ethnic groups: Russian and Tatar by means of antipyrine test.

as a test-drug antipyrine was used. Patients from two different ethnic groups: Russian and Tatar were examined. The concentration of antipyrine in saliva was determined by spectrophotometry assay. Pharmacokinetic parameters were counted by model-independent method of statistical moments K. Yamaoka: period of half elimination (T1/2, h), total clearance (Cl t, ml/min), middle time of residual drug in organism (MRT, h) middle time of elimination (MET, h), area under the pharmacokinetic curve (AUC, mkgh/ml). Statistical analysis l-criterion by Kolmogorov-Smirnov was used.

As symptomcomplex-target of pharmacotherapeutic action of Galodif clinical dynamic of neurotropic toxic effects of ethanol was analyzed in structure of alcohol withdrawal syndrome (asthenia, cranialgia, cardialgia, dissomnia, vegetative-vascular and discoordinator-atactic disturbances). Sedative, tymoleptic aspects of action of the preparation were studied in correction of affective disturbances and possibilities of impact of anticonvulsive properties of Galodif on primary pathological craving for alcohol were investigated.

Galodif was administered to 168 alcoholic patients. Preparation was administered according recommendations at dose from 300 mg a day (100 mg up to three times a day) during 15 days against the background of conventional medication as well as in post-withdrawal period during various degree of severity of affective disorders. Regarding latter part of patients that has completed course of conventional therapy further monotherapy with investigated preparation was accomplished. In the half of observations there was combination of Galodif with tranquilizers (imovan, sonopax) conditioned by severity of state of the patient (severe forms of AWS with agripnic, psychopath-like disorders).

For exception of possibility of influence of accompanying therapy on efficacy of therapy dose of drugs used in combination with Galodif was not changed throughout course of treatment. Control therapeutic group has been constituted by 30 alcoholic patients, matched to basic therapeutic

subgroup according to age, length of disease but without investigated preparation.

Information about therapeutic efficacy of Galodif have been presented in the table.

Clinical efficacy of Galodif in complex therapy of alcoholic patients

Symptomcomplexes	Number of patients with symptoms of AWS at day 3, 7, 11 and 15				Therapeutic effect (%)
	3	7	11	15	
1. Affective disturbances:					
Dysphoric	18	14	9	5	72,2
Anxious-phobic	12	10	8	6	50,0
Depressive	8	8	6	5	37,5
2. Vegetative disturbances:					
Tremor	37	37	24	16	57,9
Tachycardia	34	29	16	10	79,6
3. Sleep disorders:					
Psychovestibular	7	4	2	1	85,7
Cerebral disturbances:					
Cephalgia	28	23	15	8	71,4
Ataxia	14	11	8	7	50,0
Diencephalic paroxysms.	7	5	3	3	57,1
Cardiovascular disturbances:					
Cardialgia	11	10	8	4	63,6
Arrhythmia	3	3	2	1	66,7
Myofascial disturbances:					
Krampi	10	8	5	4	60,0

In structure of affective disturbances in patients dysphoric disorders dominate, that essentially modify actual state (behavior) of patients. Visible place in continuum of above mentioned disturbances is occupied by asthenic-depressive and anxious-phobic manifestations. Vector of normothymoleptic correction of preparation in our investigation was projected first of all at dysphoric radical of affective disturbances to significantly less degree at anxious-phobic manifestations. During stopping of asthenic-depressive disorders in patients of groups 1 and 2 preferable was conventional psychopharmacotherapy with tranquilizers of benzodiazepine spectrum. Pharmacopositive result of Galodif was observed in local muscle-tonic hyperkinesias like crampi, weakening first of all painful manifestations of hyperkinesias.

Assessing efficacy of application of Galodif in complicated forms of alcoholism it is necessary to indicate its mild vegetostabilizing action, which essential component was its balanced sympatocolitic effect with normalization of rhythm of cardiac beats and decrease of heightened arterial pressure - in 63% patients. Sensitive to action of Galodif algical manifestations in structure of cardiovascular disorders were: 63,6% cases of cardialgia stopping with preparation was possible during 5-6 days at middle degree of severity of AWS.

Out of cerebral clinical manifestations of AWS cephalgical and diencephalic disorders were most tropic to anticonvulsant action of Galodif. Therapeutic effect of preparation was noticed during stopping of these disorders already at day 3 and in most cases at day 6-7. It is important to underline that application of Galodif did not complicated discoordinator-atactic manifestations in structure of AWS. Application of Galodif for correction of dissomnic disorders as investigation has shown, it is purposeful during combined administration of it with hypnotics for use of potentiating action. Self-evident effect of application of preparation has been revealed in qualitative disturbances of sleep – "psychovestibular" dreams. In 85,7% of cases these disturbances of sleep (sensations of "going around and falls" in sleep) were stopped during intake by patients of Galodif.

Clinically evident effect of the preparation has been noticed during study of its influence on intensity of vegetoalgic and senestopathic components of headache. Accelerated as compared with control reduction of cranialgia has been revealed, weakening or disappearance of senestopathic disorders was observed and in these observations patients were not informed (for exception of suggestive effect) about character of action of administered to them preparation.

Thus, results of clinical efficacy of Galodif in alcoholic patients with comorbid organic brain

impairment have revealed in addition to known anticonvulsant normothymoleptic, analgesic and vegetostabilizing effects of its therapeutic action. Among affective disturbances Galodif is effective for correction of dysphoric manifestations. Also preparation has shown greater efficacy in treatment of cerebral (cephalgic, diencephalic paroxysms), cardiovascular (cardialgia) and myofascial (local muscle-tonic hyperkinesias like crampi) sympromocomplexes in structure of AWS.

In patients with complicated forms of alcoholism application of Galodif is effective also in phase of remission in spontaneously arising symptomocomplex of neurovegetative manifestations of primary pathological craving for ethanol so called "dry abstinence", for stopping dysphoric disorders. This allows recommending the use of preparation not only under inpatient but also in outpatient conditions as a anti-recurrent and preventive agent.

The use of antipirine of control of the drug kinetic in patients with alcoholism inclusive of the model of choice of therapy based on the data of the clinical monitoring and provides a possibility to considerably optimize the process of treatment of alcoholic patients.

We observed increase of total clearance (CLt) of antipyrine after treatment course of Galodif, decreased period of half elimination (T1/2) and middle time of residual drug in organism (MRT).

Galodif after application causes reduction almost two times period of half-elimination (T ½), significant decrease of middle time of residual drug in organism (MRT) and middle elimination time (MET), The total clearance has increased (Clt). Thus, under influence of course administration of Galodif elimination of antipirine increased that suggested induction of liver microsomal monooxigenases cytochrome P - 450 system in alcoholic patients from Russian ethnic group.

Galodif after application causes reduction almost five times period of half-elimination (T ½), significant decrease of middle time of residual drug in organism (MRT) and middle elimination time (MET). The total clearance has increased (Clt) as we observed. Thus, under influence of course administration of Galodif elimination of antipirine increased that suggested induction of liver microsomal monooxigenases cytochrome P - 450 system in alcoholic patients from Tatar ethnic group.

Galodif® accelerates antipyrine elimination in both examined groups. However, activation of an oxidizing metabolism of xenobiotics in patients - ethnic Tatar group with alcoholism is more expressed, than in Russian ethnic group.

Therefore, in Tatar alcoholic patients the evaluation of activity of P-450 isoenzymes which are responsible for toxins metabolic activation, would be useful. The data obtained allows to suggest that the individual sensitivity of organism to the drug is caused not only by biochemical, but also anthropo-morpho-physiological polymorphism.

Comparative Clinical and Therapeutic Features of Mental Disorders in North. Transcultural Aspects

V.F. Lebedeva (*Russia*)

Comparative features of mental disorders in various people were known in Russia investigations on this problem have started conducting only from the thirties of the XXth century.

In conducted by us many-year investigations in the general health care some clinical and therapeutic peculiarities of mental disorders have been revealed in patients of Tatar nationality as compared with Russians. With account for the national sign number of Tatars among patients (n = 932) with revealed mental disorders under conditions of general health care has constituted 4,1% (n = 38). Number of men (65%; n = 23) exceeded number of women (35%; n = 15) by 1,5 times, whereas among the Russians number according to nosology, vice versa women predominated (ratio of men and women has constituted 1:2,1).

In persons of Tatar nationality personality disorders (28,9%), neurotic, stress-related and somatoform disorders (26,3%), organic mental disorders (21,1%) predominated then in decreasing order affective disorders (15,8%) and schizophrenia followed (7,9%). Among patients of Russian nationality organic mental disorders (36,9%), neurotic stress-related and somatoform disorders (20,8%), affective mood disorders

dominated (11,8%), personality disorders have been documented in 4,0% of cases.

It should be mentioned that men were oftener diagnosed with personality disorders (23,6%) and organic mental disorders (15,8%) ($p < 0,05$), in women of predominance were neurotic, stress-related and somatoform disorders (15,8%) and affective mood disorders (10,5%) ($p < 0,05$). Patients with organic mental disorders were kept an eye by a psychiatrist on in 2-3 years after formation of severe psychopath-like disorders (in periods of severe pathocharacterological shifts and formation of organic psychopathy). Causes of referral of such patients most frequently were irritability, increased arousal, and conflictful behavior, sometimes of aggressive character. Duration of disease at average constituted 5,8 ± 2,8 years. Among the contingent of patients with personality disorders personality disorders of excitable and epileptoid disposition predominated. Necessity of search for help of a psychiatrist was determined by occurrence of frequent and protracted decompensations. Average long-standing of revealing the psychopathological disorders disadapting the psychopathic personality, constituted 3,1 ± 1,5 years. Decompensations manifested through affective ungovernability with anger, aggression, sense of inner tension, cruelty, and rigor in relations with the nearest ones. The psychiatrist was searched by such patients unwillingly, openly expressed their unwillingness and distrust what created certain problems during conducting the therapeutic and rehabilitative activities. Among neurotic, stress-related and somatoform disorders in patients obsessive-phobic disorders dominated (67%). Long-standing of disease constituted 2,4 ± 1,2 years, average duration of observations by physicians of a general health care unit – 1,8 ± 1,0 years. Thus, patients of the given group sought help in average in a year after occurrence of psychopathological disorders. In clinical picture of patients of the given group complaints of somatovegetative character prevailed. Patients categorically denied psychogenic conditioning of neurotic disorders. As many as 1/3 of these patients independently sought a psychiatrist for care and the rest were referred by therapists in connection with little efficacy of the conducted therapy. In clinical picture of affective disorders there weren't revealed any peculiarities. As above mentioned, depressive disorders were more often revealed in women and causes of depressions were in most cases disharmonic family relations.

Multi-dimensional conditioning of mental disorders in patients of general care required necessity of treatment at various levels. Option of therapy was built with account for precisely made mental and somatic diagnoses, premorbid personality characteristics, and social status in the period of the illness.

Comorbid mental pathology that has been revealed in 75 % of patients of the given group required administration of combined therapy because spectrum of that or another psychotropic preparation may be insufficient for stopping of multiple manifestations of complex psychopathological syndrome.

To optimize the specialized psychiatric care for every nosological form of mental disorders rehabilitative programs have been developed.

Common organizing and therapeutic approaches have been presented in rehabilitative model of medical care to patients with mental disorders, comorbid with somatic pathology.

This model integrates efforts of physicians of various specialties, activity of medical institutions of psychiatric and somatic profiles, individual biological and psychological resources of the patient, efforts of his family and the nearest.

For achievement of maximum therapeutic effect all available under conditions of a primary care unit treatment interventions were used in various combinations: psychotropic and somatotropic preparations, psychotherapeutic and psychological-corrective methods, variants of inpatient and outpatient treatment, participation of surrounding the patient in the therapeutic process.

Main peculiarity of conducted therapy was use as a basic therapy at all stages of assistance rendering psychotropic sedative preparations directed at correction of affective richness of neurotic and behavioral disorders what is likely to be conditioned by peculiarities of the temperament of patients of Tatar nationality. In choice of the therapy it is rightful to agree with statements of the authors: "temperament – target for psychopharmacotherapy, character – target for psychotherapy" (Svrahic D., Draganic S., Hill K. et al., 2002).

Studying quality of life according to the questionnaire SF-36 in the first group of examined patients of Tatar nationality before psychiatric specialized assistance rendering we have obtained reliably lower indices according to scales: social functioning (respectively 39,3 and 46,1), emotional-role functioning (44,3 and 58,2) and mental health (42,3 and 57,3) and higher indices

according to scale of physical pain (58,3 and 52,5) as compared with patients of Russian nationality.

After performed therapy in patients of Tatar nationality increase of indices according to scales of quality of life has occurred for more prolonged period of treatment (2—3 months), than in patients of Russian nationality (1—1,5 months).

Thus, patients of Tatar nationality seek psychiatric care after formation of more complex in structure and therapeutically resistant mental disorders what requires more long-term and preferably medication therapy and psychotherapeutic methods carry an auxiliary character.

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Biological Importance of Circadian Rhythms in Ecology and Adaptation

T. Zamoshchina (*Russia*)

As known the best agreement of biological rhythms, especially, circadian ones are the main marker successful adaptation. Today there are significance migrative moves of peoples to the various direction of our planet. Migrations are a new ecological factors of environment. There are many factors, which influences on human adaptation to novel conditions of life. One of the main is duration of dark and light and change of hours zone. So, human migrations leads to formation of rhythmic desynchronization of many physiological functions. Sometimes it leads to disruption of circadian rhythms or deregulation of light entrainment of the body clock. Today it is actual the search of prophylactic and correction this disruptions of human circadian system in different ecology condition.

Lithium is the thirst effective drug for modulation of biological rhythms. Lithium salts are one of the main drug of affective disorders treatment. Today in psychiatry the chronobiological hypothesis of affective disorders is wide-spread. Accordance to this conception the pathophysiology of affective disorders involves a desynchronization or disruption of circadian rhythms of central and vegetative functions. As we consider they can arises as consequence of profound adaptation disturbance of central monoamine control of circadian oscillators.

As known in a human being there are three circadian oscillator systems that are called “X”, “Y” and “Z”. They control formation of absolutely different physiological rhythms. It is believed that the oscillator of the first hierarchic level “Y”-oscillator system in mammals and human are suprachiazmatic nuclei. It has been established that neurons of suprachiazmatic nuclei have pacemaker properties. So, it was demonstrated that neurons of the left suprachiazmatic nuclei was activated at the beginning of light and neurons of the right suprachiazmatic nuclei was activated at the beginning of dark. The localization of “X” and “Z”-oscillator systems are not identified. It is possible that another nucleus of hypothalamus perform their functions. It is also possible that the epiphysis has a relation to it. Although this structure has not cells-pacemakers but a distinctive circadian metabolic cycle has been revealed in it. In addition, neurons with pacemaker properties were detected both in serotonin containing nuclei of the raphes of the middle brain and in the noradrenalin containing locus coeruleus that are connected with suprachiazmatic nuclei.

In our investigations we examine chronobiological effects of lithium hydroxybutirate on circadian phase dependence treatment on model disruption or deregulation of circadian system. In our comparative studies was demonstrated lithium hydroxybutirate is the most effective lithium salt. Disruption of circadian system was arrived at variety methods. There were inversing light-dark cycle (as we observe in migrative moves of peoples) and decreasing the monoamine control of the main circadian oscillatores. Primary chronograms were estimated using the method which was worked out for this investigation. The spectral and “Cosinor” methods were carryed out for analyses. The studies were fulfilled during winter and summer solstices and also in constant light (LL24, 10 days) and in constant total darkness (DD24, 10 days). Lithium hydroxybutirate (10 mg/kg, 8 days) was done in the beginning light or dark phase.

Thirst of all was determined three chronobiological effects of lithium hydroxybutirate. There are lengthening the circadian rhythms of activity in the beginning dark phase; increasing sensibility of rhythms to the external light-dark cycle and improving the internal synchronization between the rhythms of body temperature and behavioral activity and improving the light entrainment of circadian rhythms in the beginning light phase.

In our model experiments we demonstrated the possibility of compensation by lithium hydroxybutirate of chronobiological defect arising from destruction of the left or right suprachiazmatic nuclei of the anterior hypothalamus. In all the cases level of compensation was determined by the season of the year and circadian time of injection of lithium salt.

For example, in summer solstice destruction of suprachiazmatic nuclei only on the right resulted in arrhythmia of moving activity, but not temperature. Lithium given in the morning hours of light-dark cycle restored the 24 hours rhythm of moving activity, but in the evening hours it lengthened the period of circadian rhythms of moving activity.

As to the body temperature, lesion of the right or left suprachiazmatic nuclei resulted in only 24 hours harmonics. In the control investigation there were both 24 hours and 25 hours rhythms. Under these conditions lithium restored only circadian rhythm after destruction of the right but not left suprachiazmatic nuclei and the periods of these rhythms were lengthened.

Besides the rhythms of body temperature and moving activity we studied of circadian rhythms of Li+, Na+, K+ and Ca++ urinary excretion. The right of suprachiazmatic nuclei resulted in arhythmic of urinary Li+ and Ca++excretion and restored like control the structure of power spectrum of Na+ and K+ excretion. Besides in comparison with control the correlative connections between Li+ and Na+ increased. In the condition of disruption with right suprachiazmatic nuclei lesion lithium hydroxybutirate was administered restored the circadian rhythm of Li+ excretion, lengthing the period (26.2 h) of Na+ excretion rhythm and didn't influence on the rhythm of K+ excretion (24 h) as well resulted in arhythmic of Ca++ excretion.

In our investigations the possibility of an intervention of the lithium into activity of the circadian system was demonstrated not only at the level of suprachiazmatic nuclei but also in controlling monoamine systems, which were included in distributive system of circadian timing.

Our studies defined that raphe lesion evoked a disruption of circadian system in all light regimen. Splitting circadian rhythm of rat activity on two ultradian components was founded in winter and summer solstices and CC24. The forming of a free-running body temperature rhythm was accelerated in CC24 but, on the contrary, this process was delayed in TT24 in compare with shame operated rats. So, light cycle entrainment of the body temperature circadian rhythm was not changed but this process was aggravated for the behavioral circadian rhythm.

In winter solstice in serotonin deficit lithium hydroxybutirate lengthened the circadian rhythms of activity. In summer solstice this drug restored the sensitivity of circadian system to light : dark cycle, which were lost in serotonin deficit. In constant regimens (LL24 or TT24) lithium hydroxybutirate facilitated the forming of long free-running rhythms only in objective morning (LL24) or evening (DD24).

More interesting dates were obtained with using serotoninergic agonists and antagonists. It were buspiron and ketanserin. Buspiron is agonist of 5-HT1A serotonin reseptors and ketanserin is antagonist of 5-HT2A serotonin reseptors. In the winter solstice ketanserin provoked a powerful 21 h peak and small 26 h peak in spectrum of motor activity rhythms but in temperature spectrum there was only a single 18 h periodicity. This effects didn't depended of circadian time treatment. In this condition at the beginning light phase lithium hydroxybutirate remained the capacity for rise of motor circadian rhythm sensitivity to light : dark cycle, but not temperature rhythm. At the end light phase lithium hydroxybutirate facilitated the forming powerful 26 h rhythms of motor activity and temperature. In summer solstice buspiron reduced the sensitivity of rat circadian system to light : dark cycle without dependence of circadian time drug injection too because the short circadian periodicity was in rhythms spectrum. In this conditions lithium hydroxybutirate didn't influenced on the temperature rhythm but 12 h and 15 h peaks were predominated in spectrum of motor activity rhythm.

Locus coeruleus lesion was demonstrated the distinct effects on forming free-running and entrainment by dark:light cycle rhythms too. When in control studies the rhythms are free-running (short photoperiod, CC24, TT24), locus

coeruleus lesion was attended by difficulty the forming of free-running activity, but not temperature. And what is more temperature free-running rhythm forming in CC24 and winter soltstice was accelerated. When in control studies the rhythms are light:dark entrainment (lengh photoperiod), locus coeruleus lesion was established the lowering sensitive of rhythm activity, but not temperature, to light. So, locus coeruleus lesion induced external and internal rhythm's desynchronization at investigated illuminative conditions because of disturbance of entrainment mechanism of rhythm activity or forming mechanism of free-running.

In the noradrenergic deficits lithium hydroxybutirate in winter solstice didn't increased the rhythms sensitivity to light:dark cycle but facilitated forming of free-running motor activity only in the evening phase. On the contrary, in the summer solstice the lithium salt was effective only in the morning treatment. In this time the drug didn't restored the rhythms sensitivity to light:dark cycle too, but facilitated forming of free-running one's rhythms with short circadian period. In LL24 lithium hydroxybutirate without dependence of objective time injection facilitated forming of free-running temperature rhythms. As to motor activity the drug did it only in the objective morning. In TT24 lithium hydroxybutirate without dependence of objective time injection invariable inhibited the forming free-running temperature rhythm, but facilitated this process for motor activity only in objective dark phase.

Consequently, in our investigations was defined that disruption of light:dark cycle or destruction of the circadian oscillators evoked of various circadian rhythmic desynchronization. We proposed that weakening of endogen circadian oscillators or monoaminergic pathway to this oscillators can be reason of difficult adaptation to another light illumination. So, this model can be uses for investigation of mechanisms of human circadian desadaptation at migrationing stress. It was demonstrated lithium hydroxybutirate as effective corrector of various circadian rhythmic desynchronization. Lithium hydroxybutirate phase delayed by activation of noradrenergic pathway to evening oscillator of rhythm activity and by hypersensitivity of 5-HT1A receptors but subsensitivity of 5-HT2A receptors. Lithium hydroxybutirate improved the light entrainment of circadian rhythms by lower of central serotoninergic functional activity. Lithium hydroxybutirate improved internal synchronization by activation of noradrenergic and serotoninergic pathways to morning oscillators of rhythms of body temperature and behavioral activity. In our study was concluded about of possibility lithium hydroxybutirate for prophylactic migrationing rhythmic desynchronization and desadaptation. Chronobiological method was allowed to base the experimental arguments of existence of morphofunctional reasons of difficult adaptation to another light:dark cycle and formulate of monoaminergic conception of circadian phase dependence rhythm modulative lithium effects.

As known, circadian rhythms are the main marker successful adaptation, especially in distant human migrations to another hours zone. In different models we investigated possible central mechanisms of non successful adaptation of circadian system to the novel condition of external light:dark cycle. In our investigation we proposed that weakening of endogen circadian oscillators or monoaminergic pathway to this oscillators can be reason of difficult adaptation to another light illumination. It was demonstrated lithium hydroxybutirate as effective corrector of various circadian rhythmic desynchronization. This drug lengthened the circadian rhythms of activity in the beginning dark phase; increased sensibility of rhythms to the external light-dark cycle and improved the internal synchronization between the different rhythms and improved the light entrainment of circadian rhythms in the beginning light phase. This particularities of rhythm modulate by lithium was saved in circadian disturbance models.

Standard Symposium (SS-I-3)

Interface between the Global and Local Worlds

Chair: A. El-Dosoky (*Egypt*); CoChair: F. El-Islam (*Egypt*)

Psychosocial Aspects and Stigma in a Sample of Egyptian Inpatients

A. El-Dosoky (*Egypt*)

Background

A recent report from a global programme of the World Psychiatric Association (Sartorius & Schulze, 2005) suggests that stigma or social disadvantage attaches not only to the mentally ill but also to their families, psychiatric institutions and psychotropic medication. The stigma is particularly harsh in relation to schizophrenia.

Aims

The present study examines the various emotional, behavioural and cognitive effects of having a psychiatric diagnosis/label on inpatients, and whether the effect changes with specific disorders, total duration of illness and sociodemographic variables or not.

Methodology

A structured interview was prepared to enquire about various aspects of stigma, including feelings, thoughts, fantasies and behaviour, and to search whether there is a statistically significant correlation between stigmatization on one hand age, gender, education, duration of illness and diagnosis on the other hand or not.

The location of the study was the Behman Hospital, a private psychiatric hospital in Cairo. The study included consecutive admissions from January 2008 to April 2008 who were willing to participate in the study.

Exclusion criteria included learning disabilities, organic disorders and patients suffering from gross thought disorder rendering them unfit to participate.

Results

Two interviewers AMA & ESS had an inter-rater reliability of 0.91 on the Kappa test. 109 consecutive structured questionnaires were performed and data was analyzed using SPSS 8.0. The mean age of participants was 36.06, the mean duration of illness was 1869 days. The participants were mainly men (87 men and 22 women). The most observed diagnosis was schizophrenia and related psychoses, (n=48), Mental & behavioural disorders due substance use, and mood disorders were next (n=28), four participants suffered personality disorders as their main diagnosis, and one was in the spectrum of neurotic disorders. The most commonly answered question affirmatively was 'Do you know whether you need faith, traditional healing or help in addition to psychiatric treatment' (n=89). The least question that was answered affirmatively was 'Do you feel embarrassed from the diagnosis' (n=32). The mean total score of the 37 items questionnaire was 19.83 for all participants. The mean total score for participants who received the diagnosis of mental and behavioural disorder due to substance use was 20.5. The mean total score of participants who received the diagnosis of schizophrenia was 18.44. The mean total score of participants who received the diagnosis of mood disorder was 21.29. However, the mean total score is a crude measure to assess the severity of stigmatization. Further analysis is ongoing to detect the correlation between each item in the stigma questionnaire and each diagnosis.

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Cultural Adaptation of Psychiatric Management

F. El-Islam (*Egypt*)

The management of psychiatric disorder includes all aspects of dealing with mental ill health at the levels of prophylaxis, establishment of diagnosis and therapy. Culture has an input at all these levels.

Traditional families are more emotionally committed to their members and hence more able to prevent and compensate the effects of parental loss and mental disability. Members of traditional families develop group superegos and perpetuate the collective authority and responsibility of family elders to take decisions for healthy and sick members alike e.g. decisions on hospitalization of insightless patients, arranging marriages and fore-care and after-care of patients. Intergenerational conflict within traditional families has never been demonstrated to have pathogenic effects though it increases the likelihood of help seeking from professionals outside the family.

Knowledge of contents and limits of culturally shared supernatural beliefs is essential for all therapists in order to define illness onset and subsequent recovery. Western models of doctor expectations and goals of treatment have to be adapted to Patients' culturally conditioned expectations of greater dependence on therapists and interdependence in relation to others rather than individual independence. Establishment of a healthy therapist-patient relationship based on mutual trust is the common denominator of both professional and traditional therapies. The difference however, is that the former try to undo patients' projections on supernatural agents which the latter reinforce.

Correlation of Delusions of Persecution and Poisoning in Schizophrenia

P. Rudalevičienė (*Lithuania/Austria*), V. Adomaitienė (*Lithuania*), T. Stompe (*Austria*), A. Narbekovas (*Austria/Lithuania*), K. Meilius (*Lithuania*), N. Raškauskienė (*Lithuania*), J. Rudalevičius (*Lithuania*), R. Bunevičius (*Lithuania*)

This paper presents data on the phenomenology of delusions of persecution and poisoning in patients suffering from schizophrenia and determines parallels between socio-demographic status and personal religiosity and this type of delusions. We have studied the content of delusions in patients with schizophrenia looking for persecution themes using Fragebogen fuer psychotische Symptome (FPS). 295 patients suffering from schizophrenia participated in this study. Among whom 74.7% reported delusions of persecution. The prevalence of female patients (81.9%), who felt persecuted, was almost one third higher than prevalence of male patients (66.9%). The prevalence of delusions of persecution was lower in the group of persons for whom their faith was personally important (73.4%) than in the atheistic group (86.7%). Delusions of persecution and poisoning were strongly intercorrelated. Delusions of poisoning were reported by 57.8% of respondents: by 54.8% of males and by 60.6% of females. In multivariate analysis, the presence of delusions of persecution was more prevalent in women compared to men; in those with chronic course of illness compared to those with periodic course; in those with small size of family compared to those with large family. Personal importance of faith was not associated with prevalence of delusions of persecution and poisoning in patients with schizophrenia. Most popular types of persecutor are discussed.

Comparison of the Explanation of Mental Illness for Different Treatment Modalities and Patients

G. Szilágyi (*Hungary*)

The purpose of our research is to understand the way patients' culture determinate explanation models on help-seeking pathways and compliance with a definite type of therapy. We developed a structured questionnaire "Explanation Models of Mental Illness (QEMMI)" based on existing healing methods in Hungary: biological psychiatry, psychodynamic psychotherapy, ego-state therapy, hypnosis, spiritual healers, healthy life-style and nutrition, traditional Chinese medicine, Christian exorcism. The main evaluation topics of QEMMI are: mental illness explanation model according to the Hungarian culture, treatment model, satisfaction with treatment, compliance, help-seeking pathways.

Methods: In each treatment model 20-40 patients (unipolar depression and generalized anxiety disorder) completed the QEMMI questionnaire. We have studied how the received therapy model fits the patients' culture determinate explanation model and how this affects the patient's satisfaction, compliance and belief in the treatment plan.

Conclusion: in most cases the fit of both models has an effect on the treatment result, the compliance and satisfaction of the patient. More detailed investigation is necessary, involving a larger number of cases, to outline the general rules of the effectiveness of the correlation between the patient's and therapist's culture determinate models.

Standard Symposium (SS-I-4)

The Influence of Culture in Psychiatric Diagnosis and Explanatory Models

Chair: M.A. Subandi (*Indonesia*); CoChair: S. El-Ghonemy (*Egypt*)

The Diverse and Changing Explanatory Model of Psychotic Illness in a Javanese Cultural Context

M.A. Subandi (*Indonesia*)

The Studies on Explanatory Models (EMs) of psychotic illness in many different cultural back ground, such as among Indian (Saravanan et al., 2007; Joel et al., 2003), Ugandan (Teuton et al., 2007), Turkish (Leavy et al., 2007) British Pakistani and Western (Syeikh & Furnnham, 2000), found the diversity of the illness attribution from the perspective of the patients and families, healers, community health workers. Most of these studies, however, employed a cross-sectional method which is unable to trace the changeability characteristic of EMs described by Kleinman (1980), the pioneer of this concept.

As part of a larger project on Recovery from Psychosis in Java, the aim of this research was to understand Explanatory Models (EMs) of psychotic illness in a Javanese cultural setting. The research was conducted in Yogyakarta, Indonesia where nine participants diagnosed as having first episode psychosis were followed in the course of two years. A combination of clinical and ethnographic methodology was employed. The clinical methodology included administering Brief Psychiatric Rating Scale (BPRS) and Global Assessment of Functioning (GAF). The ethnographic methodology was conducted by interviewing participants and their families in their natural home setting. A longitudinal method was also employed enabling the researcher to look at the dynamic of EMs across two years period.

This paper explores the diverse and changing family EMs of illness that run the gamut from supernatural to psychological explanation, focusing on the extent to which families seek to minimize stigma. The result of this research indicates that family EM changes overtime following the changing of the course of the illness. It is argued that EM cannot be understood without setting them in the context of contested cultural values in Javanese setting, where traditional ideas of possession and sorcery are invoked in conjunction with more modern notions of frustration and stress.

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Relapse Predictors in Patients with Psychoactive Substance use in the Egyptian Culture

S. El-Ghonemy (*Egypt*)

Objectives

Patients who are relapse prone can be identified through relapse predictors that are identifiable and culturally colored. The essential objective of this to find those predictors among a sample of studied Egyptian Psychoactive Substance abusers and their relation to the rate of relapse whether high or low.

Methods

This study is designed as prospective study, 60 patients were included selected from inpatient unit and outpatient clinic in Institute of Psychiatry, Ain Shams University, Cairo, Egypt, fulfilling the diagnosis of substance use disorder according to DSM IV classification and subdivided into 2 groups: (A) high relapse rate who still fulfilling criteria of dependence at time of assessment and (B) low relapse rate who is abstinent for at least 6 months. Both groups were assessed by semistructured psychiatric interview sheet and were subjected to: Addiction severity index (ASI), Social Readjustment Rating Scale (SRRS), Religious Orientation Scale (ROS); with its two forms (A) & (B), Structured Clinical Interview for DSM IV (SCID); both versions I & II were used.

Results

Statistical analysis was conducted in various profiles to show the difference between groups (A) and (B) as regards: Sociodemographic, Substance profiles, Axis-I and Axis-II profiles, Religion orientation, life events, ASI profiles and the rate of relapse. Regarding sociodemographic background, it was found that educational level, employment, as well as socioeconomic state were all highly significantly ($P<0.01$) lower in the relapsing group. However, there was no statistically significant difference ($P>0.05$) regarding duration or main substance of abuse between the two groups. Also, there was non-significant difference ($P>0.05$) between the two groups as regards axis I and II comorbidities according to DSM-IV. Moreover, life events were not significantly associated with relapse. However, low internal religiosity was significantly ($P<0.05$) protective against relapse. Also, all profiles of ASI were highly significantly ($P<0.01$) associated with relapse. In addition, drug; psychiatry and legal profiles by ASI and the internal religiosity by ROS are the most important predictors in this study that should be considered when evaluating patients.

Conclusion

These results suggest that identifying these significant predictive factors for relapse can help to predict patients more prone to relapse and thus, helping in protecting against the occurrence of rapid relapse with more promising outcomes and good prognosis.

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Hypomania: Psychiatric Symptom or Cultural Habit? A Case Report

A. Gerlini (*Italy*), M. Mattia (*Switzerland/Italy*), S. Vender (*Italy*)

This article concerns the medical case of F., a 33 years old, argentinian women emigrated, with her family, from Argentina to Italy in 2001. The reasons of migration from Argentina to Italy were economicals.

A lot of facts put F. under stress during her time in Italy: she's not able to integrate successfully and she's not able to keep a permanent job. Moreover, the relation with her boyfriend is not good (they quarrel almost everyday and, sometimes, he beats her) and one of her two children suffers from autism.

In 2006 she has her first psychotic acute episode (or migration acute shock acculturation) and she has been sent to the hospital. After the hospitalization she stopped taking medications, but kept on going to the physician for psychotherapy.

Then, she has two hypomaniacal episodes between 2007 and 2008.

During the summer of 2008 she decides to go back to Argentina, and she's till there.

The main challenge with F. was to discriminate the typical habits of a young argentinian woman (for example: hyperactivity, listening to the music at full volume, drinking a great quantity of "mate") from hypomaniacal symptoms.

Additionally we discuss the approach with the Italian society through the Berry's model of acculturation. In this case emerges how the patient keeps a culture of origins and reject new culture: she falls in the marginalization situation.

That is one likely explanation to understand the origin of the psychopathology of our patient.

The case report is examined in details with the cultural formulation and is divided in five sections.

Aboriginal Concept of Time and Assessment of Mental Disorders

A. Janca (*Australia*)

Aboriginal perception of time differs from the Judeo-Christian concept of time in that Aboriginal people do not perceive time as an exclusively "linear" category (i.e., past-present-future) and often place events in a "circular" pattern of time according to which an individual is in the centre of concentric "time-circles" and events are placed in time according to their relative importance for the individual and his or her respective community (i.e., the more important events are perceived as being "closer in time").

Such an important difference in perception of time contributes to the limited applicability of currently used diagnostic and assessment procedures in psychiatry and creates numerous difficulties in providing culturally appropriate mental health services to Aboriginal people in Australia and elsewhere (Janca & Bullen, 2003).

This presentation will review methods and results of an ongoing project which aims to develop a novel and culturally appropriate set of tools suitable for the assessment of psychopathological phenomena in Aboriginal people.

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Standard Symposium (SS-I-5)
Culture, Health and Well-Being

Chair: D. Sherman (*USA*); Cochair: M.G. Weiss (*Switzerland*)

Designing Culturally Effective Health Communication

A. Uskul (*UK*)

Matching health messages to culturally salient variables such as individualism collectivism has been attempted as a means to produce health behaviour change among individuals of different cultural backgrounds. However, literature to date demonstrates that simply matching the messages to features of individuals does not always increase message persuasiveness. Building on social cognition literature, we hypothesized that matching health messages to salient cultural frames would increase persuasiveness, predicting that culturally relevant messages would be more persuasive if they came after being reminded of one's cultural frame. Thus, the present study examines the persuasive effects of tailored health messages comparing those tailored to match (versus not match) both chronic cultural frame and momentarily salient cultural frame. Evidence from two studies with European Americans and Asian Americans respectively supports the hypothesis that message persuasiveness increases when chronic cultural frame, health message tailoring and momentarily salient cultural frame all match. The hypothesis was tested using a message about health risks of caffeine consumption among individuals prescreened to be regular caffeine consumers. After being primed for individualism, European Americans who read a health message that focused on the personal self were more likely to accept the message – they found it more persuasive, believed they were more at risk and engaged in more message-congruent behaviour. These effects were also found among Asian Americans who were primed for collectivism and who read a health message that focused on relational obligations. Findings suggest that message effectiveness can be increased by reminding potential listeners of their chronically relevant cultural-orientation by making it momentarily salient and point to the importance of investigating the role of situational cues in persuasive effects of health message.

Culture, Social Support, and Health

D. Sherman (*USA*)

Social support is one of the most important means by which individuals cope with stressors, yet, what is the role of culture in the social support process? In this talk, I will examine whether Asians/Asian Americans are more or less likely than European Americans to use social support to cope with stressors ranging from health problems to relationship stressors to the mundane difficulties of everyday life. On the one hand, more collectivistic Asian/Asian Americans might prefer the sharing of problems; on the other hand, efforts to maintain group harmony might discourage such efforts.

Study 1, a survey study, showed that Asians/Asian Americans reported using less social support (emotional and instrumental support seeking) than European Americans because of the concern for disturbing social relationships.

Study 2, a priming study, showed that when primed with in-group goals, Asian Americans were less willing to seek social support than when primed with out-group or self goals, but European Americans were unaffected by priming.

Study 3 examined the effectiveness of different forms of social support. Social support without involving disclosure of one's problems (implicit support) was more effective for Asian Americans and social support involving active disclosure and verbal transactions (explicit support) was more effective for European Americans, in terms of

both psychological and neuroendocrine responses to a stressor.

Study 4 examined the effectiveness of these different social support in daily lives among Koreans and European Americans using a daily diary method. Discussion centers on the virtues and liabilities of different forms of social support within particular cultural models of relationships.

Culture, Depression and Emotional Reactivity

Y.E. Chentsova Dutton (*USA*)

Major Depressive Disorder (MDD) is characterized by emotional symptoms of prolonged sadness and loss of pleasure. We know little about the impact of MDD on emotional functioning across cultural settings. Studies of European American samples suggest that depressed individuals show diminished positive and negative emotional reactivity compared to non-depressed controls (Bylsma, Morris, & Rottenberg, 2008). This pattern may be due to reduced concern with European American cultural norms regarding emotions (i.e., fostering open or exaggerated emotional expression). Do the findings of diminished reactivity generalize to individuals from cultures with different norms regarding emotions, such as East Asian cultural norms (i.e., fostering emotional moderation based on relational demands)? The "cultural norm hypothesis" predicts that depressed individuals display patterns of positive and negative emotional reactivity that differ from their culturally normative ways of experiencing and expressing emotions. Three studies compared the emotional reactivity of depressed and non-depressed European Americans (EA) and Asian Americans (AA) to emotional film clips and to momentary elicitors of emotions in their daily lives. We assessed three components of emotional reactivity (reports of emotional experience, facial emotional behavior, and physiological reactivity). Consistent with previous findings, depressed EAs showed a pattern of diminished emotional reactivity compared to control EAs. In contrast, depressed AAs showed a pattern of similar or even heightened emotional reactivity compared to control AAs. Thus, although depression influences emotional reactivity across cultures, the specific direction of this influence may depend on prevailing cultural norms regarding emotional expression. Rather than rendering reports and displays of emotion unreliable, different cultural norms regarding emotional experience and expression may result in predictable differences in emotional responses among depressed individuals.

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Standard Symposium (SS-II-6)

Culture-Related Specific Syndromes Observed in Asia

Chair: R. Raguram (*India*); Cochair: J. Li (*China*)

Fan-Death Phobia. A Korean Culture-Bound Syndrome?

K. Lum (*USA*)

"Fan-death phobia," according to the available knowledge, observed and reported only from Korea, is associated with the strongly-held belief of the Korean people of all socio-economic and educational levels that they will mysteriously and instantly die if a fan is left blowing on them while they are sleeping in an enclosed room. This belief is so prevalent that each year newspapers in South Korean print articles blaming unexpected deaths, especially during the summer months, on "fan-induced death." Literature by South Korean physicians has been written explaining why fan-induced death is real. Fan-induced death does not appear in any other part of the world, including East Asia, but may have some relation to frigophobia (fear of getting ill due to catching cold air), a culture-related specific psychiatric syndrome reported from China. Fan-death phobia is not classified in the contemporary American classification system (DSM) as a cultural-bound syndrome. It does, however, share numerous features with culture-bound syndromes which warrant further examination and may lead to some insights into the Korean culture.

Koro Endemic among School Children in Guangdong, China

J. Li (*China*)

A rather rare but interesting koro endemic occurred among elementary school children in Fuhu village, Guandong Province in China in late May of 2004. It involved 64 cases of male students, within a period of three days. The children involved were of various ages between 6 to 15, with an average age of 11. Their grade varied between the first to the sixth grade, but were mostly of fifth or sixth grade students, with some young preschool children. No female students were involved (Deng et al., 2005).

Koro epidemics were noticed to occur in various regions of South Asia (Tseng, 2001, 267-273) and had occurred periodically in Hainan Island (located in China Sea close to Guandong) and Leizhou Peninsular of Guandong Province in the past (Tseng et al., 1988, 1992). It illustrates that koro is commonly known to occur in those regions (coastal areas southeast of China), and tends to occur when the community encounters social stress (Mo et al., 1995). However, collective occurrence of koro among children was rare, with only sporadic cases to have been reported in the literature. However, it was reported from Sichuang Province located in the central part of China (Zhang & Zhu, 1993), not in Guangdong Province.

Fuhu village is located in the coastal area of Guandong Province. In this village a endemic of koro occurred in 1963 involving about 50 adults over the period of about ten days. It was one year after the massive epidemic occurred in 1962 in the nearby Hainan Island, which was considered as the reaction to the community stress associated with the Great Leap Forward movement, in which there was an economic crisis throughout the country (Mo et al., 1995). The local village people addressed koro as suo-yang in Chinese, literally meaning "shrink of yang (penis organ)" or also as kong-suo, meaning "panic shrink". Thus, they were familiar with the phenomena and believing in its potential dangerousness.

It was in this village that the koro endemic occurred among school children in the Fuhu Elementary School. On May 21st, in the late afternoon, one of the third grade boy students, after playing ping-pong, felt his penis was shrinking, began to panic and ran home to complain to his parents. His anxious mother held the boy's penis, while his father immediately called for a local healer, an 80-years-old aged lady

for emergency treatment. The healer gave the traditional treatment of aijiu, namely moxibustion, on the boy and the alleged symptoms subsided within ten minutes after the treatment.

Two days later, on the 23rd, when the school principle learned about this incidence, he gathered all the students (393 boys and 287 girls, 680 in total) in the school together. Using a microphone, the school principle explained to the students in detail what had happened, warned all of the students to be cautious, and to take emergency measurements if they found similar symptoms. On that day, four boy students felt their penis was shrinking and ran home for emergency care by the local healers. Following this, on the next day, the 24th, 60 boy students made complaints that they suffered from koro as well, and began to panic. Except one case, all of them received aijiu treatment from the local healer. It caught attention from the departments of health and education and immediate measures were taken to eliminate the panic atmosphere through public health education. No endemic attacks occurred after this, except several years later, there were three sporadic cases reported in the village. One was an old man and the other two were young children, which occurred on different occasions.

A research team (Deng et al., 2005) was formed immediately one month after the endemic occurred and carried out a questionnaire survey of the victim cases (as study group) versus a control group among the students in the same school. It was revealed that the study group had lower scores of E (Extravert) in the Eysenck Personality Questionnaire (Chinese children version) than that of the control group (36.42±11.77 and 45.27±9.81, t= 4.54, P=0.00). Meaning that the koro tended to occur among students who were less sociable with timid personalities. Clinically, when the alleged suoyang occurred, the children manifested symptoms of panic (89%) and crying due to anxiety (33%) with somatic symptoms of palpitation (62%) and tremor (36%).

In 2008, the research team visited the village again, and used the Folk Belief Questionnaire to carry out a survey for the adults and school children within the village. The questionnaire was composed of 14 questions to study: sex belief, suoyang (koro) belief, and supernatural belief. It had been applied to people in different regions of China, namely Quangdong, Jinin (in North China) and Taiwan (Mo et al., 1995). It was revealed that the people in Quangdong, in contrast to people in other regions of Jilin and Taiwan, were not only more aware of the phenomenon, but also tended to believe more that suoyang is a dangerous condition needing help (namely: 44.5% for adults in Guandong, 10% for Jilin, and 20% for Taiwan). When this questionnaire was administered to people in Fuhu village, it was found that among the adults (61 subjects) 35 subjects (57.4%) believed that suoyang was a dangerous condition, and, surprisingly, among the school children (61 subjects) 36 children (59%) believed the same. This means that children were taught that suoyang is a dangerous condition needing immediate help.

During the interview with the local healer, namely the 80-year-old lady, it was found that, in spite of her age, she was still having sound mental condition, and is still well regarded and respected by the villagers. She still vividly remembers the koro endemic that occurred in the village in 1963, namely forty years ago, when she was in her forties. She interpreted that the endemic occurred then, due to the change of government order, (The Great Leap Movement which demanded people to work hard to promote production.) which brought evil wind to intrude into people's bodies. She interpreted that suoyang tends to occur when there is cold wind, manifested as wind sickness. She further mentioned that such ill-condition should not be treated by (Western) medicine and injection, otherwise it will result in death from such improper treatment, but only by traditional methods of aijiu, namely moxibustion, plus drinking water with chili powder (yang element) to warm the stomach and kidney. It was based on her recommendation, the victim run to her for emergency treatment.

There was no obvious environmental stress revealed in the school at the time the endemic occurred as revealed in other hysterical endemics occurring among school children, such as the one reported in literature elsewhere (Teoh et al., 1975). However, it was obvious that the reaction of the school principle, as an authority, providing a warning message to the school children, certainly provoked the endemic attack. It is apparent that the common knowledge about the suoyang, and the shared fear about the "dangerous" condition had been the underlying ground factor for the occurrence of this unique koro endemic among school children. Also, it needs to be pointed out that, the same for the sporadic case (Zhang & Zhu, 1993), it was not the children themselves, but it was mainly the adults, namely their parents (and school master in this case), interpreted and reacted in such ways

believing that the children were suffering from suoyang and was in critical condition needing immediate care to rescue them from the death pending condition.

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Categories at the margin: Towards a re-examination of dhat syndrome

R. Raguram (*India*)

Dhat Syndrome has been valorized as a "Culture Bound Syndrome", reflective of concerns about semen loss primarily among young men from the Indian sub-continent. Various theories ranging from repressed oedipal conflicts to ambivalent attitudes towards eroticism and asceticism have been advanced to explain the condition. Scholars have also focused attention on the symbolic significance of semen as a precious, sacred fluid which needs to be conserved. In addition to critically examining these diverse theoretical perspectives concerning the condition, the current presentation emphasizes the need to explore the issue from a grounded perspective, focusing attention on the experiential accounts of people. It is argued that the significance of semen loss can only be unravelled in relation to the changing socio cultural mores concerning ideas, values and beliefs about sexuality which are abstracted from everyday experiences.

Emotion regulation and social reciprocity. Hmong depressed mood in Laotian context

C. Postert (*Germany*)

There is a great cultural variety in the social phenomenology of dysphoria. The aim of this qualitative study was to compare English and Laotian Hmong semantic and pragmatic differences in depressed mood. The speaker conducted long-term ethnographic fieldwork from 2000 to 2002 among the Hmong in Laos. The social phenomenology of Hmong depressed mood tu siab, literally translated as 'broken liver', is compared to that of 'sadness' in Western contexts. The comparison reveals important semantic and pragmatic differences. Hmong 'broken liver' and English 'sadness' are deeply shaped by culture-specific premises concerning the concept of agency, of the person and of social and cosmological concomitants. Hmong depressed mood is embedded in a complex regulatory dynamics of exchange relations. Emotion regulation and the regulation of social reciprocity enhance each other in a bidirectional coconstructive process. This study contributes to a differentiated understanding of emotions in social context.

Standard Symposium (SS-II-7)

Cultural Psychiatry Research in Latin America

Chair: S.J. Villaseñor-Bayardo (*Mexico*); Cochair: R. Alarcón (*USA*)

Anthropology of Plain People in Romulo Gallegos Work

C. Rojas (*Venezuela*)

Introduction

The Llaneros played a nuclear role in the process of formation of the Venezuelan identity. During the19th century, the independence quest begins with General Jose Antonio Paez as one of its major figures. He was called The Lion of Payara and also The Centaur of the Llanos. From then on the Llaneros are singled out in epic terms from other Venezuelan ethnic groups in the formation and definition of the national soul. In the literary work of Romulo Gallegos the profile of this Venezuelan ethnic group is described, especially in "Cantaclaro" and "Doña Barbara" which were written during the first decades of the 20th century. The relationship between man and the most harsh and violent forces of an enchanted and fascinating nature, and the values, customs and culture that take place amidst life in the Llanos are all described by Gallegos not only in the daily life of the cattle ranch cowboys, but also in the tragic weave that intertwines the main characters in his novels: Santos Luzardo, Marisela, and Doña Barbara.

The Llaneros played a nuclear role in the process of formation of the Venezuelan identity. During his visit that occurred between the end of the 18th century and the beginning of the 19th century, Humboldt already wrote about the Llaneros:

Shirtless men armed with spears
travel on horseback through the savannas… …
these half-breed men -known as peones Llaneros-
are either free men or freed slaves, others are slaves,…
(Humboldt, quoted by Rago, 1999).

During this same 19th century, the independence quest began with General Jose Antonio Paez as one of its major figures. He was called The Lion of Payara and also The Centaur of the Llanos. The Llaneros participated first in the ranks of the King of Spain's army guided by the Asturian leader Jose Tomás Boves, who was called the taita (the father). Afterwards they fought more decidedly under the command of the patriot Jose Antonio Paez. From then on the Llaneros are singled out in epic terms from other Venezuelan ethnic groups in the formation and definition of the national soul. The zoomorphic metaphors of the centaur and the lion of Payara refer to well known universal archetypes. They rapidly inserted into the collective imagination and became a part of the national identity that until that moment had no symbolic products of its own (Rago, 1999; Mora Queipo et al., 2008). In Latin America the 19th century was a period of independence wars and the constitution of national states. Authors born at the end of the 19th century and the beginning of the 20th century searched into their own regional realities as sources to construct ideologies with national significance. The independence of Cuba at the end of the 19th century, the Mexican Revolution at the beginning of the 20th century, authors like Jose Marti (1853-1895), Cesar Vallejo (1892-1938), Jose Vasconcelos (1881-1938), and Jose Maria Arguedas (1911-1969), brought messages that required a new reading of our realities and a proposal of new political and social demands. In this Latin-American ideological context stands Romulo Gallegos Freire (1884-1969), a politician and writer from Caracas. He publishes the first version of his well known novel Dona Barbara in Spain in 1929, and returns to the country after a long exile in 1935, following the death of Dictator Juan Vicente Gomez. After many political ups and downs he is elected President in 1948, and deposed that same year by a military coup. This sent him away yet again into exile to Mexico, until the end of the dictatorship in 1958.

Dead Conception in Mexico

S.J. Villaseñor-Bayardo (*Mexico*)

In order to fully understand the current conception of death among Mexicans, one must go back in time at least 500 years.

In Pre-Hispanic times, the Nahua peoples stood out for their sophisticated view of life and death, which led them to integrate exceptionally well with the flow of the universe around them. The Nahua cosmology sees man as the center around which everything revolves and which gives meaning to it all. Man, together with the deities of death, is responsible for the permanence of the universe itself.

For ancient Mexicans, death was not a cause of anxiety or fear. There was no reason to run away from it: it must be faced standing up, with equanimity. It was something that, even though it was not pleasant, was accepted calmly. Life is short. Their poets – known as cuicanime – were well aware of that and expressed it often: "Just a short time here…"

The afterlife they expected was not a place of cruelty, damnation, pain, or suffering, so there was no reason to fear it. What really mattered was how they died, for their transcendence and continuity depended on it. It was not the same to die of natural causes than to die a death chosen by the gods. Nor was it the same to die as an adult or as a child. No death was more glorious than dying in the xochiyaoyotl or Flower War,[1] dying on the techcatl, the stone of sacrifice, or dying during childbirth.

Nahua funeral and mourning rites encapsulate the wisdom of a people in achieving a catharsis of the vacuum left by the deceased with their absence and going on with their everyday life. The Spanish invasion brought an end to all this, and new conceptions were imposed on the Nahuas. A strange and alien world clashed with the one they knew and owned. The synchretism that followed tried to salvage whatever was salvageable. Among great struggles, pressures, and frustrations, some of the old cosmovision managed to survive. Today, five centuries later, those synchretic elements illuminate tradition and thought in México.

In Search of El Dorado. Cultural Psychiatry Research Areas in Latin America

R. Alarcón (*USA*)

After a brief history of Cultural Psychiatry in Latin America, this presentation examines some of the main epidemiological findings among the population in this continent as distinctive features that point out to the need of analyzing cultural variables, explain the results, and understand the nature of the differences vis-à-vis other regions of the world. Increased rates of psychoses and personality disorders, growing indices of addictive disorders, and low levels of suicidality are some of these findings. Similarly, original clinical conditions (mostly somatization or somatomorp[hic disorders, a variety of "culture-bound syndromes," and the uniqueness of risk and protective factors set the stage for the description of a truly rich area of research in cultural psychiatry. El Dorado as the mythical city in Spanish colonial times in the continent whose legend stimulated bold and at times anarchic explorations provides a metaphoric background for the presentation.

Research areas that could contribute to solidify the achievements of Cultural psychiatry in Latin America include:

a) Conceptual and methodological topics such as the impact of globalization in different societal groups, descriptive precisions of similarities and differences between culture and environment, ethics of research approaches, etc.;

b) Clinical/psychopathological areas that include the use of idioms of distress, explanatory models, developmental issues in Latin American populations, and the connections between primary care and psychiatry from a cultural perspective;

c) Diagnosis and Cultural Psychiatry in Latin America, with the existing DSM-IV TR Cultural Formulation as a central point: its validity and reliability levels, possible creation of a Latin American version, comparative studies, quantifying approaches, etc.;

d) Treatment and management issues that include coping styles, help-seeking patterns, role of family and social networks, cultural psychotherapies and folkloric practices, compliance, etc.;

e) Special areas that include a spectrum of options: from the culture-bound syndromes and their special variations in the continent to ethnopsychopharmacological and pharmacogenomic varieties in various ethnic groups, as well as bio-cultural connections, through stigmatization and racism in Latin America, violence and trauma, gender, religion and spirituality, and the study of "special populations", i.e. children and adolescents, geriatric patients, women, gender and sexual orientation sub-groups, etc.;

f) Operational issues that have to do with delineation of clear research goals, training and establishment of multidisciplinary research teams, solid international cooperation in order to establish large databanks to be disseminated and compete in the world scene.

Delineation of priorities by well constituted research teams in various parts of the continent is imperative, as is a permanent openness to radical and bold research possibilities.

Healing Practices Film

M. De Noronha (*Brazil*)

In different societies, religion plays different roles in the treatment of psychiatric diseases and "diseases of the soul". A great number of psychiatric diseases have been said to have had its causes attributed to disturbances of the soul, attacks from ancestor spirits, among others. In Brazil, Christian religions as well as animist ones have enlarged the number of their legion of followers persuaded by healing practices, which have turned out to be a reference for locals.

Despite the vast range of choices of psychiatric assistance being offered, a large number of Brazilians tend to look for a mystical facet for support or treatment. So, considering these information, this work seeks essentially to propose a discussion that will address the possibility to develop social therapy that will acknowledge the patients' socio-cultural background. It will discuss a social therapy that will contemplate patients' beliefs, creeds as therapeutic resource, and that will take into account how the patients rely on these mechanisms to manage their crisis.

In the proposed social therapy the rescuing of the patients' bonds is worked together with the reorganization of their religious activities.

So, this work aims at drawing an analogy between the medical/psychiatric/therapeutic actions and the faith healing activities. We will look at the efficacy, the ethical and legal implications and the possibility of using these practices as complementary resource in assisting psychiatric patients in social therapy. A discussion will be developed centering on these issues after the film presentation showing the magical actions of faith healers.

Standard Symposium (SS-II-8)

Mental Health effects of Disasters among Ethnic Minorities

Chair: I. Ahmed (*USA*); CoChair: F. Kortmann (*The Netherlands*)

Psychosocial Consequences of Disaster

M. Llorente (*USA*)

Disasters are characterized by the extent of damage to person and property and the overwhelming inability of a community to respond to the needs of its population. Differing sensitivities, adaptive capabilities, experiences and coping techniques can have a tremendous impact on whether a disaster event builds resilience, or leads to long term psychopathology. Ethnic minority elderly for a variety of reasons may be particularly vulnerable to the long-term medical and psychosocial consequences of disasters. This session will review medical literature of the psychological consequences associated with disasters, and will present data from two studies investigating disaster preparedness among older community dwelling primary care patients. In the first study, 500 primary care veterans residing in south Florida were surveyed regarding hurricane preparedness. Of those living in an evacuation zone, fewer than half had a plan on how to leave the area or where to go for shelter. The majority were missing at least one recommended disaster supply. Fewer than half knew how to install storm shutters, despite owning them. Older adults are overall poorly prepared for hurricanes. In the second study, 17,000 veterans aged 65 and older were screened for PTSD. Veterans older than 75 were more likely to have experienced a traumatic event. Although minority veterans were less exposed, those who were experienced more symptoms. All individuals who were exposed to trauma were more likely to be at-risk alcohol drinkers than those never exposed to trauma. Those who were more symptomatic were also more likely to have experienced suicidal ideas, and reported poorer physical and mental health functioning. There appeared to be a gradient effect of increasing severity of PTSD symptoms associated with poorer physical and mental health functioning, suggesting that even subsyndromal PTSD impairs function.

Belief Systems and Coping Strategies among Ethnic Minority Elderly

I. Ahmed (*USA*)

With regard to ethnicity and PTSD rates after disasters, the existing evidence is equivocal, with data indicating either no differences between ethnic minorities or indicating a higher rate among ethnic minorities.

Black victims may be at higher risk than white victims for developing PTSD during disaster. Immigrants, including illegal immigrants, may have unique stressors due to lack of familiarity with local resources or reluctance to seek assistance. These findings appear to be confirmed in responses to Hurricanses Andrew and Katrina.

It has been proposed that differences in these ethnic groups may be due to one of two possible mechanisms, differential exposure and or differential vulnerability.

Differential vulnerability may be due some culture specific coping styles in the vulnerable ethnic groups such as collectivism or a sense of oneness with other people; the self is defined as part of a group. An extreme form of collectivism is familism, where reluctance to seek help from sources beyond the family could have serious implications in disaster-stricken settings where kin support may be depleted and insufficient to meet all needs.

Another cultural factor may be fatalism, a predisposition to attribute high causal power to the external environment and minimal causal power to personal forces. A related cultural factor is spirituality. This could manifest itself as greater

engagement in wishful thinking coping (e.g., responding to trauma with belief in miracles, faith, or luck) and/or self-blame coping (e.g., criticizing or lecturing themselves)

Other Cultural Factors include degree of acculturation among immigrants, language barriers, social isolation, socio-economic factors, historical and political factors leading to lack of trust towards authority figures, experiences of prejudice and racism, and issues related to illegal immigration such as fears of arrest and deportation

However, therapists who approach clinical situations relying on stereoptypes of large ethnic groups run the risk of alienating the patient if they do not assess the individual's adherence to cultural norms and values, which can vary greatly within a major ethnic group.

Five Strategies for Improving Disaster Planning in Ethnic Minority Communities

R. Hargrave (*USA*)

In early every U.S. disaster the majority of disaster response workers (especially those from governmental agencies) who enter impoverished minority communities who don't usually share the same ethnic/cultural background or social class as the people they serve. This situation can cause communication breakdowns, significant ethnic/ cultural misunderstandings and social class tension. This presentation will focus on outreach and educational activities two African American community based disaster response organizations, G.R.A.C.E community services in Houston, Texas and Collaborating Agencies Responding to Disasters (C.A.R.D.) in Oakland, California. These community based organizations have provided emergency response training and coordination of services to empower non-profit organizations, local community groups and faith-based organizations top provide more culturally competent care to underserved populations. The presentation will also discuss the role of African American clergy and churches concerning disaster preparedness and response.

Standard Symposium (SS-II-9)

Transcultural Clinical Setting. Western and Non Western Patient Populations

Chair: R. Terranova-Cecchini (*Italy*); CoChair: A. Arduini (*Italy*)

An Innovative Project for Mental Health of Foreign Citizens Resident in the Province of Como, Italy

M. Aliverti (Italy)

The presentation shows in summary an innovative project carried out in the mental health department of Como, along with the Lombardy Region, about the psychiatric care of foreign citizens. This project, which has the speaker as scientific coordinator, has the aim of an intervention on the existential discomfort and on the psychopathological pattern of immigrants in the province of Como, to realize an efficient integration between the psychiatric services and the social network. Some initiatives of staff training and sensibilization of the population on the specific field of transcultural psychiatry will be part of this project. The presentation will point out the primary results of this project.

Setting the Stage of a Transcultural Clinical Setting. Preliminary Results of a Protocol Design Based on the DSM IV TR Cultural Formulation

A. Arduini (*Italy*), D. Buren (*Italy*), R. Terranova-Cecchini (*Italy*), A.C. Zaiontz (*Italy*)

One might define culture as a "conglomerate of coordinates that give an individual a prefabricated vision of how they interpret their world, allowing them to develop the necessary tools to successfully interrelate within the realm of their environment" (Terranova-Cecchini, 1991). "This phenomenon manifests itself as a pattern of observable behaviours, attributed to a set point of view which gives meaning to those behaviours , through a reference point of beliefs, values and norms that are specific to its context" (Tseng, 2001). If culture is considered a network of meanings which guide and support who we are, guaranteeing efficiency in our actions and relations within the sphere of our belonging, then migration, be it for a short of long period of time, brings with it the potential for disorientation and stress.

The individual may reveal that the modality employed may not work with the same efficiency in the new environment (ref. " loss of presence", de Martino, 1961) and may find the need to invest a considerable amount of cognitive and emotional energy in facing the unique processes which in the past have generated an effortless efficiency, facilitated from a shared cultural experience

In the light of the above considerations, what are the challenges that a culturally sensitive Clinician face when treating culturally diverse patients? How can the Clinician provide patients with the necessary sense of "empowerment" that can bridge the gap of communication and facilitate mutual understanding through the diagnostic phase in order to secure strong therapeutic alliance?

The Transcultural Setting implies that the Clinician acquire a cultural competence that include:

- Understanding the role of cultural factors in the diagnostic profile and the aetiopathogenesis of the Psychiatric Disorder.
- Identifying cultural differences between Patient and Treater and promoting mutual relatedness.

- Implementing a psychoeducationally oriented phase for the patient where through a customized approach the scope and modality of treatment can be discussed.
- Constructing an "explanatory model" of the diagnostic profile.
- Growing awareness of differences and similarities between Patient's and Treater's worldviews.

Within a bio-psycho-social-cultural perspective (Mezzich, 2008) this paper explores the preliminary results of a research study in progress with the main aim of identifying transcultural response patterns through the development and administration of a protocol design partly based on the DSM IV TR Cultural Formulation indications.

The introductory protocol design, consists of 4 main areas:

- Information about 'Who We Are'
- Personal Information Form
- Clinical Evaluation Form
- Rating Questionnaire

There is circumstantial evidence indicating that the patient's level of anxiety, perceived or real, is not altered throughout the administration of the protocol and that its applicability appears independent of psychopathology thus making it an effective transcultural tool for the construction of a culturally sensitive clinical setting.

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Transcultural Psychotherapy as a Process of Symbolic Co-construction in Clinical Relation. The cultural and Migration Dynamics in a Case of Attempted Suicide

E. Riva (*Italy*)

Transcultural psychiatry and psychotherapy are gaining space and relevance in Italy, both in private profession and in public services' clinical treatment, where we encounter, thanks to the variety and the heterogeneity of the migratory flows that have invested our country in last the 30 years (Caritas, 2008; Ismu, 2008) persons with various historico-cultural characteristics, migratory percourses and intrasomatic cultures (Inghilleri, in press). Therefore the Italian Transcultural Clinical Modelsthath takes origins both from the Canadian school of Mc the Guill University and from the French School of Nathan and Moro, is developing and consolidating more flexible diagnostic and therapeutic models (Terranova, *in press*), that take in account both the variability of the cultural paradigms of the single patients and the specific characteristics of the territorial services, adapting themselves to them and constructing individualized therapy percourses, also from the point of view of the setting construction and of the transcultural instruments selection.

Objective of my intervent will be to expose, through the presentation of the case of a young adolescent recently immigrated from Ghana, brought in urgency to Niguarda Hospital after an attempted suicide, some of the diagnostic and therapeutic instruments promoted from the School of Transcultural Psychoterapy of Milan (Fondazione Cecchini-Pace), like the analysis and the use of the artefacts (Vigotskij 1934, Monod, 1970; Nathan, 1993; Inghilleri, 2003), the cultural resistance (Reidd, 1999), the metapsychic guarantors (Kaes, 1993; 2007), the cultural mediator (Luatti, 2006) and the open transcultural setting. In conclusion, it will be also shown their practical effectiveness both in the

differential diagnosis and in the successive therapeutic process.

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Culture and Psychopathology. Clinical Considerations of the Adjustment Process in a Foreign Patients Population

R. Terranova-Cecchini (*Italy*), A.C. Zaiontz (*Italy*)

Within the ongoing phenomena of globalization there is an emerging need to consider the Psychiatric Patient as a "Cultural Self" (Terranova-Cecchini, 1991) influenced by the transmission of his/her own culture and unique in their way of developing and expressing sufference. A Self that is witness to a cultural journey enriched by cultural experiences that become interwoven in own's existence, which have the potential to weaken the notion of own's Self Identity in terms of fragility, disorientation, and a sense of loss in the face of own's cultural density.

In the light of such considerations, there is a growing need for clinicians to provide their patients with a response that mirrors the complexity of their sufferance taking into account the ethnic background embedded within a cultural framework.

The Authors have focused their attention on the study of maladaptive processes and adjustment disorders which can be observed when patients are faced with challenging life events including the re location process which call for a complex and multifaceted process of adjustment and acculturation. The importance of the role played by the Cultural Self had already been identified by several scholars including Ibrahima Sow within the African Culture. His topology of the Cultural Ego has been used by the Authors in the analysis and understanding of psychological discomfort of our patients' population in the highly industrialized western society (Italy) who face the pressure of the ever changing economic, technological and social schemes of reference and values.

Maladjustment related disorders requires a careful analysis of the "dissonance" resulting from the patient's embedded culture which, as noted by A. Damasio, Kandel, Mancia and J. LeDoux amongst others, is deeply engrained in the individual's neurosystem, and the new culture the patient is challenged with

Sow underlined how psychological wellbeing derives from the assonance between own's own family inherited traits embedded in the so called implicit memory, and the cultural significance, material and immaterial artefacts to be found within the individual's community. When such assonance is altered, as a result of change within the individual's community, this can serve as a trigger for symtoms of maladjustment which can be contained if protective factors are activated.

In the light of these considerations the Authors will present the results of a study conducted on two self referred samples of patients (75 and 63 subjects) of non Italian Patients (native English speakers) to highlight the presence of Adjustment Disorders, indeces of pre and co-morbidity in their relocation process to a major Italian business city: Milan.

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Standard Symposium (SS-II-10)

Diagnostic and Clinical Challenges in Rapidly Evolving Societies

Chair: K. Ahmed (*UK*); CoChair: M. Soomro (*UK*)

The MAANASI Project

G. Jayaram (*USA*)

Two thirds of India's households are in rural areas. More than 1/3 of India's population (35%) is under age 15. Twenty eight percent of the rural population is in the lowest wealth quintile. Forty one percent of women aged 15-49 have never been schooled. Thirty five percent of women have experienced physical or sexual violence, including married women. Of 43% of married women who were employed, a quarter received no payment for their work and 12% were paid only in kind. Fifty four percent of women believed it was justifiable for a husband to beat his wife under certain circumstances. Suicide rates in some areas among young women are threefold of their Western counterparts.

Isaac and others reviewed the status of community mental health in low income countries. Limited resources, poor congruence of mental health research, practice, policy and services in comparison to developed countries, the lack of specific study instruments, lack of support from scientific journals, lack of community participation, are factors that deprive the vast majority of the citizenry from obtaining psychiatric care. A study from 4 low income countries point toward significant association of common mental disorders with female gender, low education, poverty, as well lack of access to running water in the home. Experiencing hunger, difficulties making ends meet, are strongly associated with this risk. Gynaecologic complaints are associated with an increased risk of mental disorders, and this association remains evident after adjustment for socio-economic factors. Suicide is a major public health problem. Suicide reports stem from interpersonal problems, domestic disputes, and financial problems as underlying causes, with a weaker association with psychiatric diagnoses.

Alcoholism, family history of psychopathology, and recent life events are significant risk factors for illness and suicide. Women as well outnumber men in completed suicides in India. Specific research in this area is lacking.

There are consistent reports of the increased use of alcohol in India. In one study the recorded use in a year was 21% of adult males. Dr. Isaacs and his colleagues highlight the need to examine emotional disorders of children coming to primary health care centers. Most of what is known is derived from small studies conducted in tertiary centers. Studies conducted in primary health centers where major populations resides are scarce. Mental health problems can lead to anti-social and self harming behaviors, exposure to sexually transmitted diseases, suicides, accidents in the work place and decreased productivity. A wide gap of over 30% exists between developing and developed countries. Women have less access to treatment than men. There is a paucity of data on issues relating to mental disorders, such as lack of access, and identification of priorities for care. Dr. Norman Sartorius in 2002 has pointed to barriers to treatment. Among them are low value given to mental health by individuals in society, high prevalence of mental and neurological problems, apathy toward psychosocial aspects of health and development, chronic lack of resources. Methodology, the use of instruments that are appropriately translated to the local language are other drawbacks. Maternal depression associated with childhood failure to thrive and consequential developmental delays as well as psychiatric problems have been noted by Patel, Ramon and others. Isaac and others recommend that mental health research and practice should be tied to programs dealing with physical health. Despite this, investments in resources to do so are lacking. Anxiety and depression present commonly as physical symptoms. The appearance of anxiety and depression as predominantly somatic concerns is a cultural mode of illness expression. There is a need for culture specific and national nozologies and guidelines to clinical practice. Population explosion, unplanned urbanization, scarcity of

human resources, lack of reliable data and a systematic approach to health care distribution and a referral system hamper the delivery of care. In low income countries, psychiatrists are available at the rate of 0.05 per 100 populations. Lack of health insurance burdens the family or the individual to pay for care out of pocket. Actual implementation of mental health care at the primary care level is absent. Treatment facilities for severe mental disorders vary by state to state and village to village. Training and expertise vary as well. The types and doses of medications are restricted due to cost. It is not unlikely to see patients treated with tricyclic compounds and Chlorpromazine. Among recommendations is estimation of severity, chronicity, disability and risk level of illness, education of the public in enabling them to seek treatment, epidemiologic studies on morbidity on underprivileged persons. Other recommendations made are, promoting surveys and audits of research activity in low income countries, networking with researchers in theses countries, mentoring research leaders and academic links to prevent isolation. Cost effective research methods and interventions are recommended. Management of patients by psychosocial interventions and outreach by enhancing community participation in the form of caseworkers is an effective way of using scarce and limited resources.

The WHO mental health consortium held in June 2004 highlighted the mental health needs of 80 plus percent of seriously mentally ill patients who were untreated and disabled, unable to overcome structural barriers to access care.

My presentation will be divided into 3 sections:

1. A mission to deliver care to rural, indigent mentally ill and how it was accomplished
2. Cultural barriers to care delivery and ways to overcome them
3. Incorporation of research and teaching into care delivery to establish a successful sustainable model of care.

Systematic Review of Methodological Problems in Cross Cultural Psychiatric Diagnosis and Psychometric Measurement

G.M. Soomro (*UK*)

Background

It has been argued that cross cultural diagnosis and psychometric measurement is fraught with several problems affecting validity and reliability of such procedures. However it is important to understand these problems and the extant of their impact. This is relevant in relation to the development of diagnostic categories and psychometric instruments applicable across cultures. This in turn is important for achieving universality and commonality of these assessment procedures thus facilitating communication and comparability of practice and research.

Aim

This methodological review tries to systematically search literature and critically summarises the salient problems in terms of validity and reliability of psychiatric diagnosis and psychometric measurement across cultures.

Methods

1. A comprehensive literature search is carried out using relevant terms covering the following concepts – cross cultural, diagnosis, psychometrics, psychiatry, validity and reliability; and major methodological textbooks will also be searched for relevant material
2. Articles are selected in a reliable and standardised way – thus those articles are selected if they investigated or logically argued reliability and/or validity across cultures of diagnosis or instruments
3. Articles are reliably appraised for bias and quality
4. Data are reliably extracted in terms of their content and methodological findings

Results

The review is under preparation. The data and results are extracted from articles in a reliable manner using standardised data extraction forms. The results will be presented in terms of definitions of 'culture' used and diagnostic categories and instruments investigated. The results of their validity and reliability across cultures will be systematically appraised and summarised. The methodological problems found

will be presented and discussed critically. Thus any suggestions for future research guidance will be summarised and presented.

Conclusions

Conclusions are given in terms of summary of varied problems within this complex area. Emerging suggestions for future research will also be presented and discussed.

Depression across Ethnic Minority Cultures: Diagnosis and Management

K. Ahmed (*UK*)

Introduction

Culture can influence depression in a variety of ways, and cultural differences will translate into distinct manifestations and treatment expectations of the illness. In ethnic minority communities, discrepancies in the conceptual beliefs of depressive illness between patient and doctor, the complicated effects of acculturation, stigmatisation of mental illness and various culture-specific psychosocial factors create challenges in the diagnosis and treatment of depressive illness.

The differences between depression prevalence in majority and minority communities in various countries are inconsistent and difficult to explain. It is possible that they represent a complex interplay between patho-protective and pathogenic socio-cultural factors. For example, social disadvantage, recent migration and poverty are common stressors in minority communities and could predispose to depression (Bhugra, 2001). Alternatively, certain cultural factors could protect against the development of depressive disorders, such as supportive family and friend networks (Mirza & Jenkins 2004). The effect of acculturation adds another dimension to the influence of cultural factors on the development of depression in ethnic minority communities.

Diagnostic difficulties

1. Help-Seeking:
   It has been proposed that members of ethnic minority groups conceptualise depressive symptoms as social problems or emotional reactions to situations (Karasz, 2005). This combined with the stigma of mental illness leads to problems in help seeking.
2. Underdetection:
   There is evidence that depression is under-recognised and under-treated throughout the world, especially in primary care (Ballenger et al., 2001). The reasons for this include differing explanatory models between patient and clinician, language barriers and somatic presentations, which may urge the clinicians to look for medical causation. Similar problems may arise in secondary services providing mental health care.
3. Presentation:
   As noted above, depression may present with somatic symptoms in some cultural groups. The recognition of somatic symptoms of depression, and understanding somatic metaphors (cultural idioms of distress) used to describe distress are important in diagnosing depression and treating patients from ethnic minorities who may well present in this way (Lewis-Fernandez et al., 2005).

Diagnostic solutions

The use of trained medical interpreters can result in a higher quality of patient-physician communication. Reliance on family members as interpreters may lead to serious problems in confidentiality and in evaluating issues such as suicidal ideation and sexual symptoms (Lewis-Fernandez et al., 2005).

Multi-factorial educational approaches for both the public and general practitioners, such as the Defeat Depression campaign in the UK could increase awareness and challenge illness beliefs (Bhugra, 1996).

In order to make accurate diagnoses across cultural boundaries and formulate treatment plans acceptable to the patient, the DSM-IV (American Psychiatric Association, 1994) proposes the use of the Cultural Formulation which is designed to supplement a standard clinical evaluation by highlighting cultural aspects.

Evaluating somatic symptoms with an approach that considers biological, psychological, and social factors can help primary care physicians to detect cases of depression that have

predominantly somatic presentations (Rosen et al., 1982). This is illustrated in Table 1.

1. Awareness of the possibility of somatic presentations, and enquiring about the patients' understanding of the somatic symptoms.
2. Clarifying the patients' use of specific cultural idioms of distress to describe the somatisation process and being familiar with somatic metaphors.
3. Recognition that somatic symptoms are real and not imagined.
4. Exploring physical symptoms in the context of stressors with open-ended questions such as: "What are the problems that you are facing now that create difficulty or distress?"
5. Relevant medical investigations should be performed but over-investigation should be avoided. Not conducting any tests may be negligent or taken as a sign of lack of caring. Discussion of negative laboratory or imaging tests with the patient is usually helpful.
6. Discussing the patient's physical distress in relationship to their life situation and stressors. Many patients will find a biopsychosocial interpretation helpful.
7. Rare possibilities should be considered e.g. somatosensory amplification; patients are hypervigilant to irrelevant bodily stimuli and report their awareness of bodily sensations as physical distress, and alexithymia; an extreme inability to verbalize feelings or emotional states, such patients are likely to express emotions purely or primarily with physical symptoms.

Table 1: Managing somatic symptoms of depression (modified from Lewis-Fernandez et al., 2005).

Difficulties in treatment

1. Compliance:
   Studies suggest that patients in transcultural settings are especially likely not to comply with treatment (Kirmayer, 2001). Important factors that may contribute to this include concerns around stigma of mental health services (Lawson et al., 1982), fears of the effects of medications (Cooper et al., 2003), poorer physician-patient communication, increased sensitivity to side-effects and cultural differences in expectations for treatment between patient and clinician (Lin et al., 1995; Kirmayer, 2001).
2. Pharmacology:
   Ethnic variations in response to psychotropic medication are known to exist as a result of both pharmacokinetic and pharmacodynamic differences and have implications for drug choice and compliance. Various explanations have been offered for these differences including receptor hypersensitivity (Lin et al., 1995) and slow metabolism (Kishimoto & Hollister, 1984).
3. Psychotherapy:
   It is particularly important for psychotherapists to attain 'cultural competence' to provide an effective intervention when working with patients of a different cultural background. Cultural competence can be divided into generic cultural competence which includes the knowledge and skill set necessary to work effectively in any cross-cultural therapeutic encounter, and specific cultural competence which enables therapists to work effectively with a specific cultural community (Lo & Fung, 2003).

Treatment solutions

The difficulties encountered in forming a therapeutic alliance and maintaining adherence can be minimised by negotiating a management plan with the patient, coming to a common understanding of the illness, goals, and treatment expectations and actively monitoring medication adherence (Bull et al., 2002). Diagrams and videos may be helpful adjuncts for patients with low health literacy or poor English proficiency (Lewis-fernandez et al., 2004). If the patient agrees, family members can be included in the discussion about treatments, so that they can assist the patient (Lewis-fernandez et al., 2005). Concerns about using antidepressants due to perceived harmfulness or addictiveness are common and explaining that antidepressants are non-addictive in a culturally sensitive manner may prove beneficial. The use of a model such as the ESFT, (Table 2) which was designed to improve medication adherence through enhanced patient-clinician communication may help form a therapeutic alliance (Lewis-fernandez et al., 2004).

E the patient's explanatory model of the illness e.g. What do you think caused your problem? What are the chief problems your sickness has caused for you? What kind of treatment do you think you should receive?
S social and financial barriers to adherence e.g. Do you have access to a pharmacy?
F fears and concerns about the medication or its potential side effects e.g. what are your concerns about the treatment? Are you afraid of potential side effects?
T therapeutic contracting and playback, e.g. Do you agree with the treatment we have discussed? Could you repeat to me what we agreed you would do so that I know that I explained myself clearly?
The use of a clinical tool such as Cultural Analysis (CA) which

Table 2: The ESFT model (Bettencourt et al., 1999, modified from Lewis-fernandez et al., 2005)

The use of a clinical tool such as Cultural Analysis (CA) which elaborates the DSM-IV cultural formulation and tailors it for psychotherapy can also be considered (Lo & Fung, 2003).

Conclusion

The process of globalisation and continuing migration mean that the cultural challenges we face in the diagnosis and management of depression are becoming increasingly important. Psychiatrists will have to become more sensitive to multiple belongings, multi-ethnic communities, long-distance networks and flexible identities (Bibeau, 1997). There is a need for further research into the experience and management of depression across cultures, increasing awareness of cultural differences amongst clinicians, training in culturally sensitivity and novel strategies that help overcome these difficulties.

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Pathogenic and Protective Factors of Traditional Culture on Anxiety Disorders

M. Pustoslemsek (*Slovenia*)

The transformation from traditional culture (TD) to postmodernism (PM) is taking place with different dynamics worldwide. This process is changing the impact of crucial elements of TD (role of community, religion, authority, level of reflexivity, subconscious cognitive schemes, ect.). Certain protective factors of TD are outlined, specially stability and consistency of transmission of cultural elements and partialisation of this important process in PM. One of negative aspects of PM is the projection of expectations on social institutions, wich were previously bonded on community. Special position in this structure have the transformed traditional elements, wich superficially appear as modern elements, but are active as traditional ones and may represent obstacles in the process of psychotherapy. The structure of personality can also be explained in dynamic attitudes of traditional versus modern elements, wich can be important in the psychotherapy. The protective role of alexithimia in TD is outlined and its disfuncionallity in PM.

Plenary Session (P-4)

Culture-Relevant Psychodynamic Psychotherapy

Chair: G.G. Rovera (*Italy*); CoChair: A. Bianconi (*Italy*)

Adlerian Psychodynamic Psychotherapy. Which Psychotherapy for which Person?

G.G. Rovera (*Italy*)

The area of psychotherapeutic helping relationships currently appears to be characterised by a fundamental complexity relating to the plurality of theoretical-practical, bio-psycho-socio-cultural and clinical approaches (these also concern the ethical and value-related aspects with reference to individuals from different cultures), and everything in the area of life sciences (neurosciences), living sciences (philosophical, psychological and social disciplines) and even information sciences (computer science, mass communication techniques, etc.).

In the context of helping relationships, this tends to favour a dynamic type of psychotherapeutic approach. This is based on the fact that the individual is immersed in a pre-interpreted cultural universe since birth and that childhood (through the construction of tender links intertwined with self-protective aggressive instances) is of fundamental importance to the style of life throughout his or her entire life span, from a dynamic-structural perspective. This helps to form the individual style and even the feeling towards the community.

Within a dynamic-cultural psychotherapeutic approach, Comparative Individual Psychology (C.I.P.) methodologically refers to an open network model, which uses a network of models.

This means not lapsing into epistemological absolutism or radical relativism by highlighting the interdisciplinary and intercultural dynamics which place the individual not only at the centre of the research but also at the centre of the treatment strategy.

The fundamental dynamic instances: striving for power, social feeling and/or interest and creative self favour therapeutic strategies (from supportive to intense) through the pragmatic and transversal use of the encouragement process. So the question "which psychotherapy for which person?" should be asked in the context of an interactive interdisciplinarity immersed in the debate of post-modernity and with the rigour of neuroscientific studies. This leads to a continual restructuring process of knowledge, to innovative epistemologies, and also to an explicative understanding with regard to cultural diversities. Today the theoretical-practical psychotherapeutic models of reference fluctuate between the polarity of unification/integration and that of fragmentation/eclecticism, referring back to the hypothetical nature of the search and the practice of dynamic-clinical psychotherapy on one hand, and to a pragmatic interactive plurality on the other.

Efforts and the challenges should verge towards accomplishing the translation of methods from one discipline to another (e.g. from biology to anthropology to psychopathology, etc.), which at least conjecturally presupposes a hypothetical unity of the individual (from the nomothetic – through the taxonomic connection – to the idiographic) through dialogic endeavours and permanently challenging theoretical models that are all compatible, comparable and plausible with each other.

The bio-psycho-socio-cultural paradigm of C.I.P. is recognisable in clinical practice thanks to the structured connection of different psychotherapeutic disciplines and techniques. These relate to procedural models for dynamic interventions (from bottom to top) which can also function as interdisciplinary mediation (from top to bottom). These can actually be reassembled in a sole and original individual (scientific holism) through the multiple channels and connective points of the bio-psycho-socio-cultural network.

Migration in Turin, Italy. Cultural Implications for Mental Health

A. Bianconi (*Italy*), S. Fassina (*Italy*), G.G. Rovera (*Italy*)

A.

Migratory phenomena in the city of Turin have been around for a long time in terms of domestic immigration since the 1950s and more recently immigration from Eastern European countries and non-European countries.

The following data refers to the metropolitan area of Turin (Province), which had 2,277,686 inhabitants in 2008. The sources used are: ISTAT (Italian National Institute of Statistics), Piedmont Region, the University of Torino, and the ASL (Local Health Authority) TO3 epidemiology service.

The data available in these surveys is not consistent from year to year (2006-2007-2008). This is partly due to the difficulty faced when collecting accurate statistics concerning the phenomenon of unofficial migration (illegal). The area in question had more than 129,000 foreign residents in 2008 (the equivalent of 5.8% of the resident population). It is currently estimated that overall the immigrants to make up about 10% of the inhabitants, a figure that has rapidly and constantly increased over the past 3 years. With regard to births in 2007: one out of every four new-born babies has two foreign parents and one out of three has at least one foreign parent. In addition to those who enter our country looking for jobs and better living conditions, there are also those who arrive here as political refugees and asylum seekers. There are refugees and asylum seekers from 35 different countries in Turin.

Overall the nationalities of origin are distributed as follows: Romania (34%), Morocco (17%), Albania (7%), Peru (5%), China (4%), etc. An estimated 62,700 foreigners worked in Turin in 2006. They predominantly worked in the service industry with a slightly smaller number working in industry (primary sector) and agriculture (secondary sector). This differs from other situations in Italy but is consistent with the characteristics of the region. 4% of those enrolled at the University of Torino and 8% of those enrolled at Turin Polytechnic for the recently concluded academic year are foreign.

B.

The complexity of a multiethnic, multi-religious and multilingual city definitely offers much variety and depth but it also demands that facilities and services for citizens be extensively reorganised.

Since 2000 the Italian National Health System has signalled the opportunity to take into consideration special factors linked to the epidemiological picture of the country of origin as well as cultural and psychological aspects (difficulties in communication and integrating with society). In addition to these factors, linguistic and religious issues also need to be considered.

C.

With particular regard for the subject of mental health, nowadays workers are asked not only to have much broader cultural skills but also to have the appropriate theoretical, methodological and clinical tools

Current Trends in Psychosocial and Psychotherapeutic Treatments: 5 Experiences

E. Bignamini (*Italy*), A. Bovero (*Italy*), S. Fassina (*Italy*), S. Fassino (*Italy*), C. Galassi (*Italy*), T. Levy (*Italy*), B. Simonelli (*Italy*), G.G. Rovera (*Italy*)

It is opportune to relate these five real experiences as they highlight the theoretical-practical importance of the cultural psychodynamic approach in different clinical and institutional contexts.

All those involved are clinical psychologists, psychiatrists, and psychotherapists with Adlerian training who use the psycho-socio-dynamic model of Comparative Individual Psychology (C.I.P.).

A) Ferrante Aporti I.P.M. (juvenile correctional facility) - Turin

Analysing the data concerning juveniles that entered the facility in 2006-2008 shows a decrease in the number of Italians and increase in the number of foreigners, from a variety of different countries. There is a significant increase in the number of young, and predominantly female, nomadic offenders. However with regard to males, North African juveniles are the most predominant followed by young males from Romania and Central Africa.

B) ASL TO2 Prisoner Support Service in the "Lo Russo e Cotugno" District Prison - Turin

As of 31/12/2008 approximately 50% of the prisoners were foreign. Of this 50%, 27% have substance abuse problems, whereas 89% of Italian prisoners have substance abuse problems.

The majority of the foreign prisoners originate from North Africa (Morocco, Tunisia, Algeria), then from Romania and slightly less from countries in Central Africa (Senegal, Nigeria, Côte d'Ivoire, Ghana, Gabon), followed by prisoners from Georgia, Moldavia, Croatia and the Balkan region. There are no Chinese in this prison.

Several observations regarding the psychological procedures that target foreign prisoners with substance abuse problems will be presented.

C) Regional Pilot Centre for the Treatment of Eating Disorders, Department of Neuroscience, the University of Turin, in the Molinette Hospital.

D) "Valletta" Hospice, ASL TO1, Turin

The hospice is designed to help patients that have terminal cancer and a prognosis of less than three months. The team comprises 4 doctors, 1 psychologist and a number of nurses, nursing aides and orderlies. The last two categories come from a range of different cultures - Peruvian, Romanian, Central African, Bulgarian and Japanese - and have different religious beliefs - Catholic, Orthodox and Buddhist. Practically all of the patients in the hospice are Italian.

Several observations will be presented regarding the specificity of this group of workers. Amongst other things, this group depicts a reality that is increasingly more common in the Italian health system, in which they are employed doing a variety of different jobs. There are a steadily rising number of people working in different areas of the health service that come from other cultures.

Several observations will also be presented regarding the training that these workers undergo.

E) The educational aspects clearly emerge in teaching and supervision by means of the interactive seminars run by clinical psychologists and psychiatrists trained in Adlerian psychodynamics. This training is designed for a group of 12 regional administrators tasked with managing and raising the psychological awareness of paramedical personnel in social and welfare facilities.

The target audience is the predominantly foreign workers that are assigned to caring for elderly people who are declining mentally and physically and who are subject to social isolation and existential solitude.

Cultural Psychodynamic Psychotherapy in Evolution. Issues and Challenges

G.G. Rovera (*Italy*), G. Bartocci (*Italy*), A. Bianconi (*Italy*), A. Gatti (*Italy*)

A.

To a certain extent we can see from the proposed theoretical model (1), from the reference to the migratory situation in the city of Turin (2), and from the reported example experiences (3) that the complexity regarding research and the clinical applications in dynamic psychotherapy use the practical form of the network model. Together they create a sort of framework and interactive network throughout the chains of research programmes and sympathetic-explanatory psychotherapy. The latter tends to link the biological, clinical and interpretative/supportive aspects in a cultural dimension through the multiplicity of the interventions.

This lends meaning to an individual's existence also in terms of ethical and spiritual aspects, values and also the person's dignity.

B.

This is a guideline for a challenge that involves different types of interventions regarding helping relationships (educational psychology, counselling and types of psychotherapy), which encourage the following to be used in a flexible yet meticulous manner: the theory of technique, therapeutic procedures, and the multiplicity of different working environments as well as the empathetic involvement of the workers.

C.

Therefore Comparative Individual Psychology (C.I.P.) relates to theoretical research as well as to dynamic psychotherapeutic applications in definable historic-cultural contexts. With regard to culture and its never-ending development, it also has a vast and important field of application for practical, clinical and social implications.

In terms of its basic paradigm and its ethical and legal significance, C.I.P. pertains to different operative channels, which branch out in different professions and in different training programmes.

By means of a fundamental methodological trend and consistent scientific criticism, this is a challenge that favours a genuine cultural dialogue. This means heading towards a metaphorical north star that conveys social feeling and/or interest and a feeling of cooperation towards others, a person's dignity and the meaning of life.

Plenary Session (P-5)
Geographical Beliefs On Life And Death
Chair: F. Noda (*Japan*); CoChair: D.L. Mkize (*South Africa*)

The Concept Of Transmigration of The Soul Affecting Geographical Beliefs on Life and Death of Japanese

F. Noda (*Japan*)

Buddhism has not affected Japanese life style so much but has affected their way of thinking. They subconsciously believe the transmigration of the soul of the dead.

In their belief, even after death, the corpse is with their soul. Therefore,the physical death is not the same as spiritual death. People are very hesitant to accept 'brain death ' as real death. They caress the corpse as if they were alive. They don't like it to be cut or injured. This is the major reason the organ transplant has not been so active in Japan. The soul of the dead will stay at home for 49 days after death.

This notion is related with the geographical beliefs on life and death. In Japanese concept, life and death is somehow continuity. As death is continuous with life, Samurais did not care about death for honor. This tradition surely has reflected on beautification of suicidal acts such as seppuku, Kamikaze fighters or joint suicides. "Six lives and six death: partrait from modern Japan" by R.J. Lifton (1979) described well geographical beliefs on life and death among Japanese.

The more of geographical beliefs on life and death will be presented in this session.

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The Representation of Death Between Ontological/Logical Thought and Psychological Dimension. A Critical Point of View

I. Testoni (*Italy*)

Object

This contribution considers the nihilistic conception of human existence and its conceptual structure in the western culture: darwinian-human versus methaphisical-human. The reason why it is analized this issue is to consider the actual terror and hiding of death and dying, and the difficulties to solve the argument between the methaphisical language and scientific knouledge about the representation of human life and death. The worst pain (that is essentially the terror of death) derives from this nihilistic relationship.

THE QUESTION - THE WESTERN TERROR OF THE DEATH: The "philosophy of terror", discussed by Habermas and Derrida, shows how the Western culture bases the exercise of power on the strength of terror and on the ability to keep it concealed and/or visible. In fact, the psychological dimension plays an essential role in the social dynamics in the management of knowledge and in the power that derives from it. The terror of death is largely documented in the field of the cultural thanatology. These researches study how the representations of death influence the institutions, the rituals, the beliefs, in which all human relationships are being. In the psychological area, the Terror Management Theory [TMT] (see: Greenberg, Koole, Pyszczynski, 2004) suggests the idea that awareness of mortality is fundamental in all forms of human behaviour. Based on empirical evidences, this theory – that is linked to the contributions of Otto Rank (1936, 1941), of Ernst Becker (1968, 1975), the Cognitive Dissonance Theory of Leon Festinger (1957), and that is

inscribed in the area of the Experimental Existential Psychology [EEP] – underlines the development and maintenance of culture and self-esteem as a primary means by which the fear of death becomes less painful and reduces anguish. TMT, following Darwin and all the positive sciences, considers humans as a product of evolution by natural selection, sharing with all forms of life a biological predisposition to continue existence, and to avoid termination of life. The Darwinian human is only – as Solomon, Greenberg e Pyszczynski (2004) say – man animal, a corporal creature, and it means that he is destined to wither and die. But his particular nature, that renders him different from any other species, is being highly social and vastly intelligent, that is able to be conscious of all this.

Then the TMT shows how the need to forecast characterizes human thought. In the opinion of the TMT researchers, the most important prediction concerns the need to provide the causes of death to avoid them. Social life is the construction of defensive mechanisms against conscious and unconscious dimensions connected to the knowledge of living and having to die, through the establishment of cognitive strategies that reduce anguish ("proximal" and "distal defences"). "Proximal" and "distal defences" determine the feeling of individual invulnerability or the need to have experiences that reinforce this conviction through pseudo-logical reasoning socially shared. The adherence to the prescribed standards of value from its cultural horizon Community confers two types of immortality: literal immortality - conveyed by teachings, rituals and conceptions of spiritual-religious type (immortality of the soul, there is a beyond, reincarnation, nirvana, etc.); symbolic immortality - defined by the identification of social entities (family institution, group, etc.). The cultures and world views expressed through rituals, customs and artefacts organize social life through moral and its rules that allow individuals to contain anxiety (Harmon-Jones et al., 1997). In this way, TMT considers the immortality as a "myth". The problem consists in the definition of the reason for being convinced that immortality is a myth.

Discussion

The central feature of TMT states that cultural beliefs serve as a shield against fears concerning mortality by convincing individuals that they are more than mere mortal animals. Is this the unique way to see the human dimension? Another way of understanding humans is precisely the religious way, which defines the identity of man as "what remains after death" and that consists of the principle that does not suffer the destinies of the body (soul, spirit, mana…). But as we saw, summarizing the debate on TMT, it is an individual and psychosocial defence. Is it possible to disprove the fundamental conviction of TMT? In order to show the substantial mistake of TMT and of all the positive sciences that consider human dimension like darwinian animal, it is necessary to consider the reason why this theories thing in this way. The positive thought, like the logical-positivism and the contemporary epistemology, derives from the "death of God", that is the results of the much wider debate that characterizes the western thought that led to the decline of metaphysics between the modern and contemporary ages, from Hobbes to Hume, from Feuerbach to Marx, from Leopardi to Schopenhauer, from Kierkegaard to Nietzsche, from Comte to Carnap…. The idea that considers the immortality as an appropriate strategy of the human species for biological survival consists in the conviction that life and its being is the unique dimension where the existence (with its awareness) may be exist. It means that life is an expression of the "becaming", or of the oscillation between "being" and "nothing" (like Plato taught). This is the fundamental conviction of all western culture.

Making reference to Emanuele Severino's theory (1958, 1980, 1981), that is recognized as the most important representative of the Italian philosophical school (Hoffmann, 2007), we consider the concept of nihilism fundamental because it is capable of representing the entire history of Western culture. Severino considers the matrix of Western thought to be totally inscribed in the Greek sense of the "becoming" and of the "things", that are nihilistically understood as oscillating between "being" and "nothing". This perspective describes human pain as depending on the representations with which humans are defined and in particular by that which the sufferer is convinced he/she is (Severino, 1985, 1988). Western thought, defining being as destined to annihilation, has attributed the most terrible faces to death, linking life to anguish and that of the end of existence.

Solution

And so, the solution of the problem exists, like Severino indicates, if we understand the fundamental mistake that determines the worst terror of death. Human suffers on basis to what he believes being. Severino shows how the

metaphysical tradition, that would have want to demonstrate the immortality of the soul versus the mortality of the body, did believe that the material dimension is destined to the annihilation. And, as Nietzsche considers, if something is "becoming" (or "oscillating between being and nothing"), nothing may be eternal; ergo: God and soul are impossible. But this is the radical error that derives from the same previous metaphysical error, from which the actual epistemological theories result. In fact, although like confuters, they share with metaphysical perspectives the conviction that "annihilation" is possible.

To be or/and non to be: this is the error. Severino identifies the matrix of every contradiction - which makes it impossible to think the identity (A ≡ A) - in the concept of "becoming" underlying all the Western rationality. The philosopher shows why the essence of Western thought is "nihilism". Starting from Parmenides, philosophy has irreversibly crossed the border that separates the myth / opinion (dubitable) from the truth (indubitable). Ontology is the structure of fundamental significance on which the western representation of death is formed. The necessity that "being is being" necessary implies (identity) absolutely that being may not be "nothing" (the "becoming" as annihilation is impossible). Everything is eternal, the body too. But it is necessary to pay attention very carefully, because "eternal" does not mean "immortal" and it is absolutely not similar to the metaphysical perspective. In fact, in this horizon of thought, the necessity of the eternity defines death in a new and still unknown way and confutes both metaphysic and epistemological discussion about the sense of the mind-body problem (either approaches are considered "nihilistic").

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Chinese "Positive Fatalism" and its Influence on Mental Health

X. Zhao (*China*)

Object

China is a highly unified country with huge cultural diversity. The four main-stream belief systems, i.e., Confucianism, Taoism, Buddhism and Socialism/Communism, are playing their respective roles in the spiritual and worldly life of Chinese, while they are interacting with each other in complicated games. Therefore, the beliefs of Chinese on life and death are not the simple result of a certain doctrine but a mixture of the effects of all influences. This presentation is to focus on the possible effects of such beliefs on mental health from the perspective of cultural psychiatry and systemic family therapy.

Subjects and Method of Study

This presentation is not a strictly-designed research article with samples. It is, instead, a theoretical exploration based on clinical observations and literature review.

Results

Chinese are well-known atheists or, at most, half-atheists. Confucianism and Communism have been shaping their devotion to the present life, to the social interests. Confucius encouraged his students to understand the "living life" instead of the life after death. The interests of the family, kinship or clan had been the highest value for the Chinese before 1949. Since 1949, the Communistic Materialism has been stressing the

meaning of individual's life for the collective well-being, and the people who pursue of such collective goals and who neglect, give up or suppress their own interests including their own lives are admired and valued. One of the most famous mottos of Mao Zedong was "Firstly, we're not afraid of hard and dangerous works, secondly, we're not afraid of death". Sacrifice one' self to larger social systems out of one's body is legitimate and widely accepted. Therefore, the most Chinese believe neither in gods nor in the really existing heaven or hell for the later life after death. Such a secular attitude toward present life results in that the most Chinese take care of their health very much, while some are rather utilitarian in the sense that they might abuse their lives to achieve certain social goals. This is clinically relevant.

Taoism as an endogenous Chinese philosophy is also a worldly-oriented school of thoughts. Originally, there has been no place for gods. The founders of this philosophy, Lao Zi and Zhuang Zi, appealed for respect to the natural rules – Tao, the way of the world. They laughed at intentional efforts of human being, because these efforts must be unnatural, useless and harmful. Life was seen as representation of the Tao, and death was not seen as terrible thing by the Taoist philosophers. But interestingly, this originally-atheist philosophy was then transformed into the Taoist religion in which there are personalized gods. In contrast with Confucian and Communist worldly thoughts, the Taoists religion worship special elements and powers, such as Yin-Yang, Five Elements, Chi, and so on, to prolong their lives. Such beliefs promoted the development of Alchemy in the area of religious practices aiming at longevity. In medical area, Traditional Chinese Medicine has benefitted much from Taoism. But TCM has been avoiding pursuing of supernatural power and unrealistic longevity. It realizes the limitation of human lives, while it is optimistic for the possibility to balance disturbed relationships of the elements and functions in the body.

Buddhism sees the present life as just a short and transient stage of the whole cycle of a life. It emphasizes strongly the value of the life after death. The believers have high tolerance to the hardness of life due to their beliefs in the eternity, in the kingdom come.

Beside the above-mentioned four thoughts, the Western cultures, capitalism and market economy are influencing the attitude of Chinese toward life, death and health. The increased prevalence of anxiety disorders, "metabolic syndrome", sudden death relating to so-called "Type-A behaviour ", are just a few examples demonstrating the changing conception of life of Chinese.

Conclusion

It is necessary to understand the mentality of nowadays' Chinese. They are no longer the Chinese whom the Western have seen decades ago. Generally, they are still worldly-oriented, family-centred, flexible, optimistic, peaceful, harmonious, and tolerant in the most time, because they follow still the natural and positive views of world, views of life and death. Meanwhile, some new trends have also emerged that the Chinese are changing their conception of relationships regarding self and environment, body and mind.

Geographical Beliefs on Life and Death in South Africa

D.L. Mkize (*South Africa*)

South Africa is a country with diverse cultural, religious, social, cultural and political beliefs. This diversity leads to a difficulty in discussing a specific South African belief system. This presentation will be referring to the Nguni Tribe of South Africa.

Life begins long before conception. Life ends long after death. These beliefs Systems will be discussed at the conference.

THIRD DAY - September 29 (Tuesday)

Plenary Session (P-6)
SCIENCE AND FAITH.
Cultural Psychiatry and the Study of Religious Living Societies

Chair: A. Hornblow (*New Zealand*); Cochair: J. Obiols-Llandrich (*Andorra*)

Has the World Entered a New Era of Religious Intolerance? The Case of Usa in the Bush Era

R. Wintrob (*USA*)

The United States constitution has enshrined the principle of the separation of church and state. The principle has been repeatedly challenged in the courts and always upheld, through more than 230 years of the life of the republic.

During the administration of President George W Bush, himself a fundamentalist Christian, that principle has been ignored and undermined.

President Bush appointed as his attorney general a fundamentalist Christian like himself, who strongly supported and encouraged active participation of religious institutions and principles in government policies regarding birth control, abortion, 'end of life', scientific research using embryonic stem cells, foster care, education, broadcasting, court appointments and the treatment of prisoners.

This presentation will describe some of these policy changes, and their societal implications. It will conclude with reflections on the fragility of fundamental legal and ethical principles of government during the Bush era, and the promise of the restoration of those principles in the Obama era. It is a morality play in three acts.

Psychology and Psychopathology of Messianic-Prophetic Movements

L. Jilek-Aall (*Canada*), W. Jilek (*Canada*)

This paper summarizes some of the Authors observations and information on so-called "Cargo Cults" in New Guinea, as an example of an indigenous messianic-prophetic movement.

"Cargo Cults" arise from a syncretistic ideology based on the fusion of traditional Melanesian mythology with the salvation message of Christian missions. Such messianic movements in Melanesian cultures are typically initiated by charismatic prophets. Inspired by visions or dream revelations, the prophet proclaims the advent of apocalyptic events ushering in an earthly paradise of abundant wealth and social equality for Melanesians and the return of their ancestors with all desired goods believed to be withheld by the "Whites". Successful prophets exhibit a high level of intelligence and eloquence and are perceived as messengers from the supernatural world, exerting a powerful suggestive influence on followers, sometimes leading to phenomena of mass dissociation. In some cases they show megalomaniac behaviour and paranoid ideas. Failure of their prophecy to materialize is attributed to faulty performance of required rituals and to the "Whites" not revealing the secret of magic access to free cargo, sometimes also to the lack of an expected human sacrifice. With the help of a deputy leader and organizer, the cult may evolve into a religious congregation or into a socio-economic and/or political organization.

Psychiatry, Religion and Dictatorship

J. Obiols-Llandrich (*Andorra*)

Beyond the general title of this presentation, its object is considering a very concrete situation: Spain and Spanish psychiatry during Franco's dictatorship (1939-1975). The religion is what we can call the Spanish version of Catholicism, the cult that has been widely prevalent in Spain, specially since the expulsion of Jews and Muslims at the end of the 15th century. There has been for centuries a long-standing tradition of intolerance, hardness and association to the political power by the side of Spanish Catholicism. Franco's successful rebellion against the secular Spanish republic meant a reinforcement of the more morally strict rules in all aspects of Spanish society. The so-called "National Catholicism", a trademark of the fascist regime, implied a lack of human rights and freedom, censorship and repression. For Spanish psychiatry, the new regime meant the exile of the best professionals and the influence of German nazi psychiatry mixed with fundamentalistic, ultranationalistic ideology. Francoist psychiatrists considered that theology had to impregnate the practice of psychiatry: vice would be destroyed by imposing religiosity and patriotism and a severe social discipline was in need. According to these ideas, a Spanish national psychotherapy was proposed, where psychoanalysis was rejected: too subversive, too involved with sexuality. The Spanish patient was supposed to reach spiritual goals, forget about desire and repress the "dark, evil forces of the unconscious". All this ludicrous theories did not survive as new generations of psychiatrists grew up in Spain and completely dismissed these dogmatic issues.

From the mid '60s on, new winds blew in Spanish psychiatry at the same time that the Catholic Church began to lose its ideological influence. We must conclude that Franco's dictatorship was a complete disaster for the Spanish society. The alliance of the Catholic Church with the fascist power was a real shame and this dual influence on Spanish psychiatry was ill-fated. Nowadays, Spanish psychiatry is a modern and vigorous discipline. And blame it to Franco's times, Spain is, maybe, one of the more secular countries in the whole world.

Plenary Session (P-7)

Immigration and Acculturative Stress in an Era of Fear and Terrorism

Chair: R. Wintrob (*USA*); CoChair: LJ. Kirmayer (*Canada*)

The global 'War on Terror' and the psychology of demonization. A Canadian perspective

L.J. Kirmayer (*Canada*)

This presentation will explore the impact of the current climate of fear about terrorism on the mental health of immigrants, refugees and visible minorities in Canada.

Canada has been a nation of immigrants from its inception with about 18% of the current population born outside the country. Although migration policies have always been discriminatory, the post 9/11 climate of fear has fostered a new level of suspicion with increases in racism, discrimination and exclusion.

In Quebec, a political debate on 'reasonable accommodation' focused on the extent to which the dominant society should adapt to the values and practices of newcomers. This debate singled out specific religious and cultural groups (Muslims, Jews and visible minorities) and allowed xenophobic and racist elements of society to voice their fears and hostility toward whole segments of society. The heightened concerned with security has had negative effects on the health and wellbeing of both children and adults among minority groups and newcomers as documented in surveys and clinical work. In addition to this impact on vulnerable groups, mistrust of the 'Other' damages the fabric of civil society with potentially negative effects for everyone.

The dynamics of this mistrust will be illustrated with cases drawn from our cultural consultation service.

The Canadian ideal of multiculturalism requires renewed commitment to counteract the stereotyping and exclusion that have resulted from the political manipulation of fear.

Islamophobia and the mental health of muslims in the Uk post 9/11

S. Dein (*UK*)

There has been an escalation of anti-Muslim sentiment in the UK following 9/11 largely fuelled by the public perception of Islam as fanatical, and fundamentalist.

"Islamophobia" is a term deployed to refer to forms of prejudice, exclusion and violence toward Muslims that have risen to new levels over the past 20 years. Islamophobia contributes towards health disparities among Muslim minorities in terms of both physical and mental health. Two processes mediate disparities: intersectionality and differential racialisation. "Intersectionality" refers to cases in which individuals or groups experience prejudice toward multiple attributes of their identity.

Muslims in the UK and the US are differentiated by race, ethnicity, national origin, social class and immigration status, any of which can result in being the target of social bias. "Differential racialisation" means that each minority or targeted group becomes defined in relation to a given majority group, often in terms of being "more" or "less" similar.

These issues are discussed in relation to new immigrants in the UK. Religious discrimination has significant effects on mental health. Discrimination at work and "chronic daily hassles", including insults and assaults, can increase the risk of common mental disorders such as anxiety and depression. It can also influence access to and the use of health services.

The presentation ends by discussing how these cultural issues can be overcome in health-care related settings, particularly focusing upon the importance and limitations of cultural competence training.

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The coping process of adult refugees resettled in New Zealand

A. Hornblow (*New Zealand*), M. Pahud (*New Zealand*), J. Gage (*New Zealand*), R. Kirk (*New Zealand*)

A significant proportion of the international research concerning adult refugees has investigated clinical perspectives and emphasised the impact of pre and post-migration experiences as key factors affecting their mental health status (Colic-Peisker & Tilbury, 2003; Guerin & Guerin, 2007; WHO, 2007). However a clear understanding of their mental health problems and psychiatric morbidity is difficult to obtain due to major prevalence variations and discrepancies between studies. Further, the clinical perspective tends to understate the negative impact of resettlement barriers on individuals mental well-being (Tribe & Summerfield, 2002; Walters, 2001). Recent studies in New Zealand have also underlined the limitations of health providers' ability to meet refugees' mental health needs (Briggs & Macleod, 2006; Guerin et al., 2004).

Despite the acknowledgement of refugees' endurance in overcoming traumatic events during their pre-migration flight and in their first asylum countries relatively less is known about their capacity to show positive adaptation to life's tasks in the course of resettlement in the final host country, and how this impacts on prevention or alleviation of mental health problems. This study (Pahud, 2008) was undertaken, therefore, to describe and explain, and develop a theoretical understanding of adult refugees' coping processes in overcoming resettlement difficulties and adjusting to life in New Zealand.

Using grounded theory methodology (Corbin & Strauss, 2008), qualitative data were collected from twenty six former refugees, originally from the war torn countries of Afghanistan, Burma (Myanmar), Ethiopia, the Kurdistan region, and Somalia, all now living in the New Zealand cities of Christchurch and Nelson. Semi-structured interviews and follow up sessions were conducted with all participants, the latter to clarify and verify their own experiences against the emerging findings of the research. From the different factors identified by participants as contributing to their coping processes, four major categories emerged; their personal resources, formal support from resettlement services providers, the support of caring individuals, and the participants personal achievements. The basic social process of obtaining a social position was described as being the main goal which motivated them to develop their coping skills and behaviours following resettlement in New Zealand. Participants explained that this was underpinned by the inter-relationship of their personal resources and gradual personal achievements, which were influence by encouraging external support from providers of resettlement services, and "caring" New Zealanders. Data collected during this study suggest that this dynamic process, in which personality and environmental factors interacted in a reciprocal and transactional relationship, appeared to be the sine qua non to negotiate and manage resettlement challenges. Indeed, participants frequently emphasised that if this interaction was not activated they faced greater difficulties in coming to terms with their new environment and their adjustment to life in New Zealand, thus leading potentially to adverse mental health outcomes. In addition to the social process model developed using grounded theory methodology, quantitative socio-economic data were collected to describe participants' characteristics and circumstances.

The study's findings underline the complexity of adult refugees' coping processes as well as some of the institutional, social and environmental constraints hindering their adaptation process, which can result in mental stress. The implications of supporting the development of former refugees' personal abilities, so as to guide practical support and strengthen multisectoral interventions, are outlined and discussed.

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Standard Symposium (SS-III-11)

21st Century Cultural Issues

Chair: J. Streltzer (*USA*); Cochair: D. Goebert (*USA*)

Psychosomatic and psychiatric disorder among Iraqi refugees/immigrants who immigrated to USA at different period of times

H. Jamil (*USA*)

Objectives

To enhance the knowledge base regarding the impact of Gulf Wars (GW) on the health of the Iraqi people & mainstream communities and to exploring the outcome which could help the participants in recognize, diagnose, manage and prevent those disorders.

Hypothesis

We hypothesized that the Iraqi, post GW-1991 group [G 1] of immigrants would report higher levels of medical conditions [Psycho-somatic and psychiatric disorders].than the group who immigrated between 1981-91 [G 2] which could also show a higher frequencies of medical conditions than the group who immigrated pre-1981 [G 3] due to the accumulation of stresses leading to their immigrant status.

Also we hypothesized that the Iraqi who immigrated at these three periods will follow the same trends for receiving treatment for their medical conditions.

Background

Thousands of Iraqis immigrated to the U.S. before 1980 for a variety of reasons, predominately economic, while those who immigrated during 1980-1991 were due mainly to the fear of the family from taking their male children when they reach age of 18 to serve in the Iran war and from the stress of the régime (Nassar-McMillan, 2004; Nassar-McMillan, 2007; Jamil et al., 2004; Jamil, et al., 2006). On the other hand, those who immigrated to U.S. after GW 1991 up to 2003 were mainly refugees or because of the impact of GW 1991 environment and the sanction on the Iraqi government which affect the people themselves. Most of post GW Iraqi immigrants, suffered a sequence of serious traumas in Iraq either before, during, or after the GW. This influx of immigrants has presented a public health care challenge since many of them have suffered the various traumas of wartime, first from the Iraq-Iran war in the 1980's and then from the Kuwait GW 1991 (Kira IA, 1999). Many of these have experienced multiple relocations, temporary settlement in refugee camps, and many have been traumatized by witnessing the death or torture of loved ones or friends (Via et al., 1997). Comparing three waves of Iraqi immigrants could serve as a useful strategy for determining how the groups are similar and different on a variety of reported health measures especially psycho-somatic and psychiatric disorders, remembering that Iraqi refugees perhaps represent a population with the highest potential exposure risk to toxic materials during the GW.

Methods

The study project was announced to the Iraqi community. Study population were selected randomly (7.5%) from list of 5490 address. The response rate was 95.4%. A standard questionnaire was used (Iowa Persian Gulf Study Group, 2002; 8. Participants were interviewed about their self-perceived health, including their mental health. The interviews took 2-3 hours each. Participants received a gift certificate for $25.00. Study population were classified into three groups according to the year enter U.S. The first group, Post-1991, [G1=205] was considered at high risk exposure to GW environment. The second group, are those who immigrated to U.S. during 1981-1991 [G2-80] which was considered as the group who were exposed to the stress and fear from Iran war and the regime, while the third group were those who immigrated to U.S before 1981 [G3=65] which could be considered as control group especially to those who immigrated after GW 1991 [G1]. We apply chi-square contingency table to examine the associations between the three study groups among all available variables. We calculated the prevalence for each medical condition [Psycho-somatic and psychiatric disorders] and whether or not the individual had been treated or not. Logistic

regression analyses were used for each medical condition after adjusting to age, marital status, occupation and health insurance. In the second set of analyses we contrasted the G1 (post-1991) with the combined other two groups (G2 & G3) on the medical symptoms (for this analysis we classified the 33 medical conditions which were asked the participants into three categories and as follows: Psychiatric, Psycho-somatic & Somatic disorders) using Logistic Regression with Group (G1=1, G2+G3=0) as the outcome. Other control variables e.g. age, gender etc. were also included in the mode. For the final analysis the outcome was the answer to the question "would you say your current health is excellent, very good, good, fair, or poor". We were interested in the extent to which this outcome could be predicted by the 3 medical symptoms [Psycho-somatic, Psychiatric and Somatic disorder] scores. For this purpose a path analysis was used with selected significant demographic variables as exogenous variables and the medical area scores as mediating variables.

Results

There were significant differences between the three groups regarding age, marital status, occupation and health insurance. However, 59.5% of participants in G1 rate their health condition at the time of interview as fair/poor compared to 25% in G2 and 12.3% in G3, these differences were significant but it became non significant when G2 was tested Vs G3. For medical conditions [Psycho-somatic and psychiatric disorders], results shows that G1 have higher prevalence rate in all medical conditions. However, examining each of these medical conditions shows that 9 out of 11 were statistically significant different between the three groups. Similar results come out when Logistic regression analysis was apply after adjusting to age, marital status, occupation and health insurance. However, the prevalence of treatments among medical conditions was range between 87.5% [Asthma] and 39.4% [Sleep apnea]. Results for the path analyses are shown in figure 1. All the path coefficients shown are significant at $p < 0.05$. We first note that G1 has a direct path to Current Health Rate (CHR) as well as indirect effect mediated through each of the three health areas [Psychiatric, Psycho-somatic and Somatic disorders]. Employment has a direct effect on CHR and an indirect effect through the psychiatric and psychosomatic area scores. Education does not have a direct effect on CHR but does have an indirect effect through the psychiatric area score. Finally age has direct effect on CHR but not on the mediating variables. The model fits the data well on all three main fit indices [chi-square (8.53, df=7, p=0.29), GFI (0.99), RMSEA (0.03)]. The R2 for prediction of CHR model was 0.49.

Discussion

Results will be discuss and compare with other studies. However the prevalence of the medical conditions among G1 were similar to other Iraqi study but it was higher than other Arab immigrants 9,10,11. We hypothesized that the people who immigrated after 1991 would report medical conditions at higher prevalence rate than their colleagues who immigrated prior to 1991 [G2 & G3]. We found this hypothesis supported in most medical conditions. However, no particular trend in describing the relationship between levels of treatment sought with reported medical conditions although G1 shows better respond to treatment than G2 & G3 which indicate that Iraqi people need a comprehensive education about the important of having treatment for any health disorders to avoid complication of that disorder. Path analyses confirmed the expected effects of arriving time, employment, education, and age. Later-arrival (post-1991) people (G1) have a worse CHR score than people who arrived earlier (G2 or G3); employed people have better CHR score; higher education made for a worse CHR score; and older people are more likely to have worse CHR scores.With regard to mental disorders, among those who met the classifications for depression and Psychiatric disorders, participants from G1 [Refugee], post-1991 immigrant group comprised 65 % or more of each of the groups.

Conclusion

Our results, based on a random selection of Iraqi immigrants, suggest that the mental health impact of the Gulf War was more severe than prior conflicts in Iraq. These findings are of relevance considering the expected increase of Iraqi refugees expected within the next couple of years.

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The impact of cyberbullying on substance use and mental health. Ethnic and gender disparities

D. Goebert (*USA*), I. Else (*USA*), C. Matsu (*USA*), J. Chung-Do (*USA*), J. Chang (*USA*)

As technology use among adolescents has increased, so too has cyberbullying become endemic.

Cyberbullying is a form of bullying which can be defined as an aggressive, intentional act carried out by a group or individual, using electronic forms of contact, repeatedly and over time against a victim who can not easily defend him or herself.

Using mixed methods approaches, we explored violence among Asian and Pacific Islander youth.

A community-university partnership was established to direct the research. In phase 1, nine focus groups among Filipino, Native Hawaiian and Samoan youth were held to discuss interpersonal violence. Cyberbullying emerged as a major theme. Cyberbullying was seen not only as a root cause for fighting but also as well as a key contributor dating violence victimization, especially among girls. For example, Filipino girls reported expecting to have their cell phones and e-mail monitored by their boyfriends.

In phase 2, 887 students from two multiethnic high schools on the island of O'ahu, Hawai'i were surveyed on interpersonal youth violence and a multitude of risk and protective factors. Nearly 20% of youth had been victims of cyberbullying in the last year. Filipino and Samoan youth were more likely to report feeling bad about themselves as a result of cyberbullying. Cyberbullying is also related to symptoms of binge drinking, suicidal attempts, and depression.

In Phase 3, we are working with the schools and community to develop gender and culturally appropriate prevention approaches. Cyperbullying is widespread and part of the everyday adolescent experience. However for some youth, particularly Filipino and Samoan girls, it can have devastating outcomes. Developing PSAs and interactive plays with youth is just one way we have used to share information. Strengthening families and school-based programs on building positive relationships provide promise for reducing youth violence in these communities.

Clearly, a multifaceted approach that involves youth, family, community members, school counselors, teachers, and administrators and university personnel are needed.

Internet related sexual behaviors and the law. An examination of cross-cultural differences

D. Kellaher (*USA*)

The internet has become a primary resource for individuals all over the world to feed pathologic sexual behaviors.

For instance, individuals with high libidos may seek online media or anonymous sexual liaisons with ease and relative anonymity. Paraphilic sex offenders may access deviant stimuli and exchange provocative media without having to leave their home and with less risk of criminal ramifications. In particular, online child pornography has become a publicized international problem that is dealt with variously in different countries.

This presentation intends to examine cross-cultural differences in the way sex and psychosexual pathology may be viewed based upon differing sanctions across the globe against internet related sexual behavior.

The influence of modern culture on pain management

J. Streltzer (*USA*)

While the influence of culture on psychopathology is widely accepted, the influence of culture on general medical practice has received much less attention. Traditionally, interest in culture and pain related to cultural differences among patients and how that affected pain symptoms

In the United States, Canada, and some other countries, a "medical culture" has developed that influences pain management more than the cultural background of the patient. It is called a "medical culture" because it involves specific values and beliefs with regard to pain management. Examples include the belief that pain is commonly undertreated, that only opioids can treat moderate to severe pain, and that opioids remain efficacious over the long term with difficulties rarely arising because of tolerance or addiction. These beliefs lead to the assumption that chronic pain should be treated with opioids in response to subjective complaints.

Because of these beliefs, practice trends and research evidence have been moving in opposing directions. In particular, opioid prescriptions for chronic nonmalignant pain have risen exponentially, despite increasing evidence that this approach is neither safe nor effective. Chronic opioid treatment appears to be associated with worsening of painful conditions. Chronic stimulation of the mu opioid receptor causes an upregulation of neuropeptides that enhance pain sensitivity. These include dynorphin, cholecystokinin, and substance P. The newly discovered mechanisms by which chronic opioid intake induces hyperalgesia are multiple and overlapping.

This "culture" of pain management needs to be recognized so that resulting problems with patient care can be minimized.

Standard Symposium (SS-III-12)

Social change, natural disaster and mental health in China

Chair: X. Zhao (*China*); Cochair: Y. Yang (*China*)

Adaptation and family dynamics of internal migrants in Shanghai, China

X. Zhao (*China*), S. Miao (*China*)

China is experiencing a historical migration wave due to its opening-and-reform policy since 1979. Shanghai is one of the largest cities in the world, and it is still growing rapidly as it has been the locomotive of the Chinese economy. Its population increased from 10.98 million in 1979 to 18.58 million in 2007, and half of them are migrants in twenty years. Many of them are migrated with nuclear families. The most new comers to Shanghai are so-called "internal or domestic immigrants" from various provinces, while another small part of them are overseas Chinese, Taiwanese and foreigners. Because of vast geographic and sub-cultural diversity among Chinese, the immigrants must face and adapt the new environment in Shanghai, while they have much more opportunities than in their home provinces. In this process, the structure and function of family changed a lot.

Research the family of migrants will help to understand this process better, and help clinical intervention also. The authors reviewed the relationship between migrant and mental health, the method of family research, reviewed the theory resource and application of the basic tool in this research-systemic family dynamic self-rating questionnaire.

Subjects and Method of Study

The research collected the data of adolescents and their parents from five different type middle schools in Shanghai Pudong New Area with aim sampling. The final samples were 1059 adolescents, 709 fathers, 750 mothers. The migrant adolescents were 611 (57.7%), the migrant fathers were 395 (56.4%), and the migrant mothers were 437 (59.0%). The main tool of this research included systemic family dynamic self-rating questionnaire, Index of Well-Being and General Affect, Symptom Checklist 90. The statistical tools were SPSS13.0 and Lisrel8.51.

Results

The research found the gender ratio, single-born ratio in adolescents were different between local and migrant, city and country, good socioeconomic and bad socioeconomic families. The school choosing was related parents education background closely. The average education level of migrant parents was lower than local parents, but polarized than local parents. The social support of migrant family was weaker than local family, but the subjective and objective life level was similar between migrant family and local family.

The systemic family dynamic self-rating questionnaire was used mostly in adolescents before, i.e., the adolescents evaluated their origin families. In present research, the parents were also invited to evaluate their families.

Through exploratory factor analysis, confirmatory factor analysis, reliability analysis, this research validated that the systemic family dynamic self-rating questionnaire could evaluate the current family by parents also. Confirmatory factor analysis showed that the four dimensions of the systemic family dynamic self-rating questionnaire represent different aspects of family dynamics independently. In the individual level, the research found: (1) the local family members had better family dynamic appearance, less symptom, more happiness than migrant family members. But socioeconomic status was important effect on this differences; (2) the rating scores of adolescents and parents were dissimilar. On average, adolescents reported lower family dynamic appearance, more symptoms and less happiness; (3) the school choosing was related parent's education, and schools affected the symptoms and happiness of adolescents also. In the family level, through comparisons of centralized and discrete directions, construction the structural equation model, the research found:

(1) The relations of migrant family members were closer and tighter than local family members, and the construction of migrant family member were more similar; (2) The family level was different from the individual level, and the migration process was an important influencing factor on family dynamics; (3) On the family level, family atmosphere and disease conception were important influencing factor on mental health. Dimension Family Atmosphere was a basic dimension in family dynamic; (4) Dimension Individuation influenced adolescents more than parents; (5) Dimension System Logic influenced parents more than adolescents; (6) Dimension Disease Conception was a dualistic dimension, both protective and risky.

Conclusion

Through investigating the family dynamics and mental health of the migrant family and local family in Shanghai Pudong New Area, the research found: (1) the systemic family dynamic self-rating questionnaire could used in evaluating the current family by parents; (2) the mental health of migrant family were poorer than local family, but which is not obvious in higher socioeconomic family; (3) the family dynamics have more important influence on mental health of migrant family than on local family.

Epidemiological investigation on mental disorders after 512 Wenchuan earthquake in China

J. Li (*China*)

Objective

The purpose of the present investigation was to assess the possible change of prevalence of mental disorders after 512 Wenchuan earthquake occurred in China, with particular concern of PTSD.

Methods

Target areas surveyed were Dujiangyan, Beichuan, and Qingchuan in Sichuang province, three of the ten very heavy disaster areas as reported by the Chinese government. 10% of the victim-population of the 15 temporary sites, which accommodate more than 5000 victims, were randomly surveyed in accordance with their gender and age. Screening tool used were: 1) The self-designed general questionnaire; and 2) 12 general health questionnaire (GHQ12). Diagnosis tool applied was SCID-I / P, examined by psychiatrists with at least 5-years professional experience.

Results

Population coverage was 1.03 million and 14,257 subjects were surveyed face to face. According to GHQ12, the results showed that: high-risk population was 16.08%, mid-risk was 13.51% while lower risk was 70.41%. The time point prevalence of all mental disorders were 82.62 ‰, which showed an obvious increased tendency comparing with the data obtained from the 1993 national epidemiological investigation on mental disorders in 7 areas of China (which was 11.18‰). First five rank of prevalence are respectively as PTSD (18.49‰), anxiety disorder(14.00‰), depression disorder (12.67‰), the mixed disorder of anxiety and depression (10.21‰) and alcohol abuse (8.31‰), which showed great difference with those data from 1993-national study. Less difference were found among the prevalence of major psychiatric disorders such as schizophrenia and affective disorder; and organic-related mental retardation, such as Alzheimer's disease and mental disorders due to vascular disease. Prevalence of PTSD from this investigation (18.49 ‰) was lower than reports from other disasters (34-113 ‰) studied in the past.

Conclusion

After Wenchuan earthquake, it was revealed that, the time point prevalence of all mental disorders showed an obvious increased tendency comparing with data from the 1993-national epidemiological survey. The first five rank of prevalence are: PTSD, anxiety disorder, depression disorder, the mixed disorder of anxiety and depression, alcohol abuse, mainly of minor psychiatric disorders (or so called neurotic disorders). The prevalence rate of PTSD was lower than that reported from other disaster studies carried out in the past. The study supports the notion that more attention is needed for

prevention and treatment of minor psychiatric disorders after the severe natural disaster.

Culture-resource-oriented psychological resilience for post-Sichuan earthquake survivors. A community recovery model

Y.Yang (*China*)

A devastating earthquake struck Wenchuan County of Sichuan Province in China on May 12, 2008, resulting in 69,185 deaths, 37,471 injuries, and 18,458 people missing. Overall, more than 45 million people were affected directly or indirectly.

This presentation will introduce a post-disaster community psychology recovery model that has been developed. Several issues are to be emphasized. First, the collective aspects of the model will be presented. This includes collective experiences of trauma and recovery emphasizing the resilience and natural self-help resources available within the communities. Second, the importance of tapping into the local community resources, drawing upon the rich heritage that is available and embedded in the local culture. Interventions designed around local folk-customs and skills such as local handicraft, collective belief in understanding disaster and a rich history of local interdependence will be described. Third, the model is developmental in nature, with interventions designed according to the needs that are characteristic of the various stages of disaster relief. Finally, the multi-disciplinary aspect of the model will be discussed. Specifically, this presentation will discuss how the interventions are designed and delivered by an integrated community recovery team comprised of psychiatrists, physicians, counselors, social workers as well as the survivors themselves.

This presentation will provide both a theoretical framework and practical experiences that may assist in the planning of future interventions designed to serve the Chinese population.

Standard Symposium (SS-III-13)

Marginalised People, Minorities and Bio-Cultural Issues in Psychiatric Management

Chair: C. Pace (*Malta*); CoChair: M.H. Braakman (*The Netherlands*)

Ethnicity and routine CYP-genotyping. Clinical relevance

M.H. Braakman (*The Netherlands*)

Even today most available drugs are mainly tested among western Caucasian subjects. In comparison we still lack a lot of knowledge about effects and side-effects of drugs in non-western populations. Thanks to the work of Keh-Ming Lin and many other scholars (Chen CH, Chen CY & Lin KM, 2008) in the last few decades there is an increasing amount of studies delivering us an increasing amount of new facts in the area of ethnopsychopharmacology.

From these studies we know that large interethnic differences exist both in the area of pharmacokinetics (what the body does to the drug) as well as in the area of pharmacodynamics (what the body does to the drug).

These pharmacokinetic differences are due to factors like age, gender, diet, comedication (herbs or drugs) as well as genetic factors. As far as the metabolism of drugs through hepatic CYP450 enzymes 2D6 and 2C19 is concerned, genetic variation is the most important factor explaining these differences.

Raises the question whether genetic genotyping of the genes producing these enzymes has any clinical relevance. Genetic genotyping of metabolizing enzymes could give the clinician an indication for adjusting drug dosage. If genetic genotyping could have this clinical advantage there should be at least a clear and clinically useful correlation between drug dosages, the individual genotype and the blood level of the drugs concerned. In order to answer that question the author performed a routine CYP450 genotyping of both 2D6 and 2C19 using the recently introduced Amplichip technology (de Leon, 2006) in 20 ethnically divergent subjects. In order to establish a real clinical significance 'real world' patients are needed, i.e. no exclusion criteria were accepted. The sample consisted of patients who almost all used psychiatric and somatic comedication which influenced drug blood levels as well.

In the presentation at the conference the author will describe the details of the subjects studied, the methods used and the results.

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Suicide in Prison. A Transcultural Perspective

A. Grochowska (*The Netherlands*)

Studies of prison suicide present rates of suicide in custody. Most studies base their suicide prison rates on the average daily population in prison, that is the average number of inmates in the population on any one day, and compare their rates to those of the general population.

The U.S. prison population increased in the last decennium and was over 2 million in 2005. The number of inmate suicides increased along with the prison population. The seeming increase in prison suicides appears to be due to the large increase in the prison population, as suicide rates have actually decreased over the last twenty years.

Across the sample of prisons in Poland, Czech Republic and Hungary, the incidence of self-harm (and suicide) decreased over the last ten years. Overcrowding, bullying (especially in juvenile prisons) are the main current issues.

Suicide rates in prisons are though considerably higher than in the general population, both in the United States and the

United Kingdom. In the United States, the rate of suicide in jails is estimated to be 8 times higher than in general population, and in England and Wales, the age-standardized rate of suicide among male prisoners is 5 times higher than in the general population. In addition, these rates remain high after leaving prison.

The data on prison suicide in other European countries are comparable. In Austria the prison suicide rate is three times higher than the rate in the general community. In Italy the prison suicide rate has risen from four to ten times the community rate. In Switzerland the data show a rather high rate of prison suicide (14 times higher than the rate for the free community). In France 115 prisoners committed suicide in 2008, an 20% increase on 2007. Risk factors are boredom, tension and depression. In the Netherlands the age- and sex-adjusted suicide rate is seven times higher than the rate in the community. Relationships were found between harassment, threats and suicide in Dutch penal institutions.

Prevention of suicide in prisoners is a key component of the WHO suicide prevention project. An important aspect of preventive strategies is detection of those at highest risk. It may not be possible to generalize from suicide research in the general population. Some factors associated with suicide in prisoners differ from those associated with suicide in general population. Being married is often associated with lower risk in the general population, but this may not be the case in prison. Across many studies a suicide risk was elevated in the first week of custody and in those with drug and alcohol problems, psychiatric disorders, suicidal thoughts, and long sentences.

Although the understanding of the role of potential risk factors in prison suicide is increasing, there is still little known about underlying processes. Theories on the high suicide rate in prisons range from these which focus on the psychopathology of the prisoner to those which focus on the influence of the stress of institutionalization. Durkheim (1987) proposed that the suicide rate of a society depend on the level of social integration (the degree to which the members of the society are bound together in social networks) and the level of social regulation (the degree to which the desires and behavior of the members of the society are governed by social norms and customs). The question is whether suicide rates in prisons show correlations with the social characteristics of the society (particularly with the divorce- and birth rates). The current research data are not conclusive, partly due to the research objectives themselves.

The possible role of individual variables has obviously dominated studies of suicide in prison for many years. With the development of interactive theories in criminological research more attention has been paid to environmental factors. According to some recent studies both individual vulnerability and prison-induced stress should be taken under consideration in preventing suicide in prison. The single commonest motive for prison suicide is still the inmate finding the prison situation intolerable.

The aim of this presentation is 1. to provide data on suicide rates in prison in different countries, 2. to compare demographic, criminological and clinical factors across countries. 3. to give some guidelines for suicide prevention in prisoners and future research.

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A new masters on immigration in the central mediterranean

C. Pace (*Malta*)

The 11,000 sub-Saharan immigrants that have arrived on boat on Malta have turned it the EU's smallest and most densely populated country into the world's highest recipient of asylum seekers population-wise, infinitely more so space-wise. This paper is about our Department's challenges in launching an MA Social Policy or Social Work, particularly its 50% concentration on migration.

The MA caters for persons from various professional groups or roles that respond to, through policy or service, to migrants and related issues, especially the central Mediterranean context, such as Malta, Italy and Spain.

It caters for both caring and controlling capacities. Qualified as social workers can do the social work stream, while persons with any related qualifications can apply to the social policy stream, whether qualified in social or public policy, sociology or anthropology, psychology, counselling or particular health professions, etc., or qualified people active in any service related to migration.

This raises a number of challenges. How can exposure to both caring and controlling values, human rights and national interest, administrative service delivery, daily care, psychosocial needs and an openness to relevant psychotherapeutic aspects be all presented in ways that encourage openness to multiple viewpoints while giving space for a balanced personal assimilation of relevant material? How can all roles and clusters of competencies be improved or consolidated in openness to the competences, roles and viewpoints typical of other groups, without an inappropriate blurring of attributed roles and competences? What control models are both effective and humane?

How can intercultural competence or psychosocial and health care keep a balance between a general competence, open to new and plural cultures, and a special intercultural competence related to sub-Saharan Africans, by far the most numerous immigrants, not sharing a homogeneous culture, but still helpfully identifiable commonalities? How can the internships or placements be appropriately run?

With its accent on social care, and the psychosocial support of immigrants within the reception and integration process, the course will carry a significant ingredient of transcultural psychiatry, psychotherapy and counselling. Of course, a participating psychotherapist will make a different use of this from a training social worker or, in turn, administrator or border policeman.

We are grateful for the interest shown by some persons in the international transcultural psychiatric community in the course. We would also be grateful for offers of contributions to enhance the teaching, the curriculum details and bibliographies and sources on particular areas.

"It's His Right to Beat Me". Women's acceptance of culture-dictated norms perpetuating partner-inflicted violence against women

B. Pillsbury (*USA*), S.R. Schuler (*USA*)

Goal

Participants will understand that women are not simply victims of sexual and partner-inflicted violence, but victims of cultural norms that teach not only men, but women as well, that it is the husband's (or intimate partner's) right to beat the woman for even minor irritations.

Method

Synthesis of findings by the anthropologist author during 25 years of participation and leadership in program interventions on gender and women's health, complemented by literature review.

Findings

Violence against women and girls is a problem of pandemic proportions. "Violence against women and girls continues unabated in every continent, country and culture. It takes a devastating toll on women's lives, on their families, and on society as a whole. Most

societies prohibit such violence — yet the reality is that, too often, it is covered up or tacitly condoned" (UN Secretary-General Ban Ki-Moon, 2007). Perhaps the most pervasive human rights violation known today, it assaults mental health, devastates lives, fractures communities, and stalls development.

Statistics paint a devastating picture of the health and social consequences of violence against women. For women aged 15 to 44 years, violence is a major cause of death and disability. In a study about risk factors facing women in this age group, violence against women rated more significant than cancer, war, malaria or motor vehicle accidentsi. At least one out of every three women around the world has been beaten, coerced into sex, or otherwise abused in her lifetime — with the abuser usually someone known to her (World Bank, 1993). Often it is her husband or other intimate partner.

"Domestic and intimate partner violence" includes physical and sexual attacks against women in the home, within the family or within an intimate relationship. Women are more at risk of experiencing violence in intimate relationships than anywhere else. In no country in the world are women safe from this type of violence. Among countries surveyed by the World Health Organization (WHO 2005), more than 50 percent of women in Bangladesh, Ethiopia, Peru and Tanzania reported having been subjected to physical or sexual violence by intimate partners, with figures reaching as high as 71 percent in rural Ethiopia. Surveys from around the world document that about half of the women who die from homicides are killed by their current or former husbands or partners.

Legislative prohibition on domestic violence has been enacted in about 90 countries and a growing number of countries have instituted national plans of action to end violence against women (World Bank, 1993). This is a clear increase from earlier years. Yet high levels of partner-inflicted violence against women persist.

Cultural underpinnings rarely reported: A major reason for ongoing husband- inflicted violence against women is that many traditional societies still consider it normative. Specifically, in these cultures many men believe they should hit or beat their wives in order to extract from them desired behavior, ranging from sexual satisfaction to presence in the home, food preparation or even stilling a crying child. Even more troubling, data (from India, Africa and elsewhere) indicate that many wives, even more than husbands, tend to believe that a husband is entitled to beat them when they fail to meet his expectations.

Discussion

Will address issues of immediate concern to cultural psychiatrists.

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Standard Symposium (SS-III-14)
Culture, Humor and Psychiatry - Part 1
Chair: R. Wintrob (*USA*); Cochair: R. Bennegadi (*France*)

Culture, humor and psychiatry. A synthesis in Jewish culture
R. Wintrob (*USA*)

The long history of the Jewish people has been characterized by loss, discrimination and persecution, by suffering and anguish, by being ghettoized and expelled.

Yet, it could be said with equal accuracy, that the history of the Jews has been one of extraordinary accomplishment; in the pursuit of truth and justice, in the sciences and medicine, in the arts and humanities, in business and finance, in politics, in religion.

And, of course, in the liveliness of Jewish humor.

The themes of Jewish humor reflect the fears, worries and troubles central to the Jewish experience of being a mis-understood, discriminated against, diasporic people; one that has lived as a resented and often feared minority in every country the Jews have inhabited.

Fears of powerless, ridicule and exposure are, therefore, fundamental themes in Jewish humor. Missed opportunity is lamented. Self-disparagement is often observed. Envy of the easy life imagined to be characteristic of other peoples is often seen.

The fundamental fear inherent in contemporary Jewish culture is that assimilation and inter-marriage will become so prevalent that Jewish culture itself will disappear.

These are the issues that will be explored in this presentation.

Humor and death in Mexico. Skulls and laughter
S.J. Villaseñor-Bayardo (*Mexico*)

Skulls made of sugar in Mexico are a representation of death with very human features, appearing as Don Quixote mounted on "Rocinante", or as an outlaw, or a bike rider, a bullfighter, a mason; someone wearing a fashionable hat; or bearded or with Kaiser-style moustache These representations of death are in no way intended to be scary; but they are an allusion to the inevitable ending of life. They are neither disgusting nor more frightening than living people, with all their foibles and personal eccentricities.

These Mexican skulls are not extra-human. They are not intended to be ghoulish nor to stimulate macabre fantasies. Death, as represented by these Mexican skulls made of sugar, is not the demonic adversary of humans, but is portrayed as part of life itself.

In Mexico, humor is closely linked to death; and fear of death is denied by laughing at death and its human-like representations.

In this presentation, I will discuss Posada's calaveras. José Guadalupe Posada was an artist who made jokes about death. His illustrations and poems not only had a critical or satirical connotation, but also a eulogistic or festive connotation.

Death is a universal theme of human expression. The way in which we deal with it, the familiarity, the tenderness, the sensitivity with which Mexico regards death, its obsession that is neither tragic nor funereal, but nuptial and natal, its immediate everyday nature, its imperious and serene visibility, its burbling laughter rather than a moan, contain the unwritten wisdom of a cosmic, playful conceptualization.

Culture, humor and psychiatry. Various examples of humor in Japanese culture

T. Akiyama (*Japan*)

Japanese humor has long historical background and relies on non-verbal elements. Themes are mostly from daily life and hardly political. I present three modes of Japanese humor.

The first mode is Kyogen, which was imported from China during 8th century and developed during 14th century as comical intermission of "Noh". Kyogen later influenced the development of Kabuki significantly.

The second is Rakugo, which originates from story collection during the 13th century and was developed during 17th century, Edo era. The stories are set and the tellers try to excel in performing a few characters with extremely tactful manipulation of non-verbal expressions.

The last example is Manzai, introduced during 11th century as part of new year festivity, but drastically transformed during 20th century. In modern Manzai jokes are exchanged with a great speed, but non-verbal elements still play significant roles.

With the influence of Western culture the Japanese humor now relies more on verbal contents. However, gesture or facial expressions are still the keys to make people laugh. This reliance on non-verbal element has certainly contributed to refine delicacy in Japanese culture, but may have also inhibited verbal assertion.

Culture, humor and psychiatry. A syntesis in mediterranean culture

R. Bennegadi (*France*)

The joke caricature had always covered a wide geographical area stretching from North Africa to Egypt and the eastern Mediterranean, and then facing immense challenges.

This paper, covering the Mediterranean area, shows how humour invents all kinds of ways that allow a distance from oneself and from others, and thus enables people to cope with the difficulties of social life and the suffering caused by them. In societies where, most of the time, censorship and self-censorship prevail, and where many social, religious and political taboos remain tenacious, humor is a way of "passing" a message that otherwise could not be done. This synthesis is an effort to analyze the "connections" between the individual and cultural unconscious elements and their social–group determinants.

Standard Symposium (SS-III-15)

Spirituality, Meanings, and Suicide. A Multi-Multural Perspective

Chair: E. Colucci (*Italy/Australia*); CoChair: H. Hjelmeland (*Norway*)

Spiritual care. The context of spirituality as it is described in three different researches

I.O. Karviven (*Finland*)

In this oral session I am going to go through three different studies about spirituality. Aim of this session is to show the wide spectrum of the meaning of spirituality in its medical and sociological contexts.

The purpose of the first quantitative study was to clarify if the nurses in the psychiatric hospital have abilities to meet patients' spiritual questions and what sort of these abilities are. The research was carried out in Kuopio University Hospital, in its psychiatric unit. The results show that nurses take the patients spiritual needs into consideration in many different ways.

The second qualitative study describes multicultural spiritual care as reported by registered nurses. The aim of this study was to increase the knowledge of multicultural spiritual care, to asses nurse's attitudes towards it and to asses their educational needs. Nine nurses were interviewed for the study. They all were working in the Northern Savo region in Finland. Research material was analyzed using the inductive content analysis. Results of the study show spirituality as a multidimensional phenomenon in multicultural nursing care. Spiritual care seems to be part of good quality nursing care.

The third research belongs to the research field of public health and medical sociology and it describes spiritual health using an ethno-philosophical approach. The research was carried out as an ethnographic research in the hospital of Kendu Bay and in the village of Kendu Bay and its surroundings in the province of Nyanza, Kenya. This area by Lake Victoria is inhabited by the Luo tribe. The aim of this research is to produce information about spiritual health and to describe the conceptions of spiritual health by the Kendu hospital staff and the inhabitants of the Kendu Bay village. The results created a model of the spiritual conceptions of health.

Conclusions

Spiritual care is recognized as an important part of good nursing care. The context of spirituality is multidimensional and hard to describe. According the first two studies nurses felt that they have inadequate preparation to deliver spiritual care. It is recommended that the delivery of spiritual care can enhance nurses' resources enabling them to better care holistically for their patients.

Suicide attempts, meaning of life and other dimensions of spirituality. Reflections about case studies of 4 French outpatients

J. Andriamananaivo (*France*)

Background

We hypothesize that:

- suicide issue is related to spiritual area, spirituality with or without religion
- spirituality is multidimensional (meaning, value, beliefs, support, committment…)
- spiritual aspects may have influence on the outcome of the patient's suffering. They may be assessed through patient's discourse.

In France, spiritual and religious aspects are overlooked in clinical assessment and care of suicide attempts.

Aims

Analysis of patients's discourses:

- to recognize words and sentences that seem to be relevant for them

- to explore relationship between these words and dimensions of spirituality, inside their cultural and personal context.

Method

Interview of 4 consenting adult patients followed in the author's private office.
The assessment tools:

- Profile questionnaire
- HAD scale (Sigmond /Snaith)
- Semi-structured interview concerning spiritual beliefs and religious practices in French language, by MOHR and al. (Geneva, Switzerland).

This semi-structured interview is audio recorded, transcripted and processed by a software used for a textual data analysis, called ALCESTE.

Results

The textual data analysis of discourses enables us to describe 3 classes of words.
For each class the following main results:

- the most significant words and sentences (using chi-squares to measure the importance of the links),
- the recurrent segments,
- the concordances of the most characteristic words.

Interpretation and Discussion

•CLASS I: verbs related to « act »: to see, to go, to say, to do

•CLASS II: related to difficulty to find solution to problems

•CLASS 3: related to identity

Discussion is made about relationship between these words and patient' s personal and familial history, dimensions of his spirituality, his current clinical condition.

Conclusion

This study proposes a qualitative approach of relationship between spirituality and suicide attempt.

No definite conclusions can be drawn from these isolated case studies, but it points to main dimensions of this relationship. This survey is a testing process of a subsequent protocol which will include a larger number of patients and will examine quantitative (statistical) and qualitative aspects.

Spirituality, religion and attitudes towards suicide in Ghana and Uganda

B.L. Knizek (*Norway*), H. Hjelmeland (*Norway*), C. Akotia (*Norway*), V. Owens (*Norway*), E. Kinynanda (*Norway*)

Attitudes towards suicide and suicide prevention were studied among psychology students in Ghana (N=570) and Uganda (N=289) by means of the Attitudes Towards Suicide Questionnaire (ATTS; Salander Renberg & Jacobsson, 2003). In addition to a number of questions to be answered on a five-point Likert scale, two open-ended questions were included: 'What do you think is the most important cause of suicide?' and, 'What do you think should be done to prevent suicide?'. In this paper, only the results of a qualitative analysis of these two questions are reported. Both in Ghana and Uganda religiousness was important and in general the attitude towards suicide was negative. This is in line with a number of previous studies having found that religious factors are associated with negative attitudes toward suicidal behaviour (e.g., Colucci & Martin, 2008; Domino, Cohen & Gonzales, 1981; Domino & Miller, 1992; Domino, Niles & Raj, 1993).

However, in general there seems to be a stronger normative tendency among the Ghanaian students, while the consequences of war and AIDS seem more important for the Ugandans. In the Ghanaian sample statements describing suicide as an act of cowardly behaviour were found, while this was not present among the Ugandans to the same degree. The vast majority of the students believed that suicide could be prevented. Mainly they pointed at necessary changes at the societal level with special emphasis on the construction of an effective health service with counselling facilities. Suggestions on improvement of the religious counselling services were mentioned relatively often in Ghana, but not in Uganda, and one can question whether the division between health services and religious services is as clear in Ghana as elsewhere. In their responses to both questions, the Ghanaians revealed a stronger emphasis on morality, even

though students in both countries seemed to be equally occupied with the necessity and fruitfulness of religion in order to understand and prevent suicide. The implications of this need to be further studied and discussed.

Spirituality/religion, beliefs in afterlife and youth suicide

E. Colucci (*Italy/Australia*)

In spite of the recognized importance of spirituality for people with mental illness and people at risk of suicide, it is still an overlooked area in Suicidology. There are few studies addressing this topic, 'religion/spirituality' is usually regarded as just one among a series of variables and it is generally measured with a single question. Studies on non-religious forms of spirituality are rare.

In this symposium, Colucci will give an overview of the "state of the art" in this area of research and present findings on spirituality/religion, beliefs in afterlife and suicide from her multi-method studies with young people from different countries. In particular, she will focus on her latest study in India. She will also show some of the photos she took during this latter fieldwork (a selection of the photos will be shown at a conference venue).

Colucci will conclude her talk with considerations on the role that spirituality/religion might play in suicide prevention.

Standard Symposium (SS-IV-16)

Progress in Apology and Reconciliation. A Future Role for Cultural Psychiatry in Healing from Trauma

Chair: S. Wolin (*USA*); CoChair: S. Okpaku (*USA/Nigeria*)

Post conflict resolution and reconciliation. A multicultural perspective

S. Okpaku (*USA/Nigeria*)

In spite of globalization and international statements about world peace, we continue to witness man's inhumanity to others in local, regional and international arenas. This symposium will illustrate how certain communities or groups of individuals have shown resilience and have been able to forge resolutions in post conflict situations.

In the 1950's and 1600's we witnessed the fulfilment of national aspirations of many groups in Africa for autonomy and independence from colonial domination. In some cases, the transition was smooth and developmental; in others the change was or has been accompanied by severe conflict. Examples of these conflicts include the Biafran war, the Conpolese experience, the fall of apartheid in south Africa, and the reconciliation efforts in Rwanda. The reconciliation efforts in these instances are varied with varying results.

In this paper we will attempt to describe some of the major African conflicts and remarkable attempts at reconciliation. The role of traditional methods of reconciliation including the ceremonial and symbolic sharing of blood and food will be explored. In addition, we will document some extraordinary examples of individual or family resilience.

The issues of forgiveness on corresponding rituals will also be addressed.

The place of apology in conflict resolution among Africans. A cultural psychiatry perspective

S. Ilechukwu (*USA*)

Conflict and war are collective experiences and always disruptive not only of personal psychology but also the socio-cultural matrix in which humans can function well. In the matter of war conflicts and attendant human rights violations (HRV), psychiatry, like other medical specialties, has tended to focus on the study and treatment of the effects on the individual person whereas it may be best positioned appreciate and facilitate the restoration of the socio-cultural matrix. Admittedly, societal transformation, resolution or mediation of war and other situations in which HRV occur are not now seen as the domain of mental health experts but cultural psychiatrists may have the special sensitivity and knowledge to shift their focus to serve as experts in groups who serve these objectives. We reference the Truth and Reconciliation Commission (TRC) which played a prominent role in post- apartheid South Africa in which out of 17 commissioners there were 3 mental health experts (or 4 if you count the physician commissioner).

This presentation offers 7 vignettes of African approaches to justice and conflict resolution: 1. The case of the restless "nwokpu": a Nigerian case of persisting extended family conflict from the sale of a female into slavery about 200 yrs ago by connivance of some her relatives. 2. The Okonkwo solution to a murder in a fictional work in Things Fall Apart by Nigerian novelist Chinua Achebe 3. A Nigerian men "found guilty" of magically killing an extended family member condemned to die by voodoo death. 4. Mato oput process in northern Uganda. 5. The gurtong process in conflict resolution in Uganda. 6. The Nyamussorro cleansing rituals in Mozambique and 7. The Umuvumu Tree project in post genocide Rwanda that is working thru practical Christian approaches to promote apology, making amends and reconciliation. Cases 1 and 2 invoked outdated amend making and bridge building through an involuntary marriage relationship that were not only unsuccessful but originally meant for low level conflicts. No apology is involved in

this cases. In case #3 a reconciliation effort failed because the suspect failed to apologize appropriately. In Mato oput apology is required before the ritual cleansing and community acceptance ceremony. Gurtong is a ritualized public acting out of blunting of a spear (traditional instrument of war) by opposing or combating groups after making token amends for a killing. There is no formal apology but making amends is often proxy for acceptance of responsibility. In nyamussorro rituals individuals involved in killing or war are explicitly not held responsible but required to be cleansed before ritual reintegration into their communities.

The vignettes reveal some templates preexistent in African cultures that are consistent whith indigenous patterns of relatedness even though they may not always contain explicit apology components. In their primordial form, they may not be suited to the magnitude and complexity of the conflicts in modern day Africa. The task of cultural psychiatrists may be to identify indigenous approaches such as some of those highlighted and adapt them to manage the psychological traumata attendant on recent and current wars and HRVs in Africa.

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The Rwandan experiment in reconciliation following the 1994 genocide

S.J. Wolin (*USA*)

10 years after one of the most gruesome genocides in history, the President of Rwanda began releasing perpetrators who were willing to confess their crimes and stand before local gacaca courts.

At this time nearly 60,000 killers have been released from prison returned to their villages, and stood to face their victims and neighbors in more than 11,000 tribunals. With the public apologies of the perpetrators and the responses of their victims to the request for forgiveness, we have a unique natural laboratory to study the reconciliation process and Rwanda's attempt to end a national state of trauma. Are the apologies trustworthy? Is the reconciliation process authentic? Video material from an interview with a murderer and the surviving member of the victim' family will allow symposium participants the opportunity to evaluate for themselves.

Standard Symposium (SS-IV-17)

Socio-Cultural Shifts and Mental Troubles in Young People

Chair: H. Kuramoto (*Japan*); Cochair: F. Noda (*Japan*)

Recent mental health troubles among employees in their twenties and thirties in Japan

L. Kurabayashi (*Japan*)

Objectives

The objectives of this study are to introduce the depressive state shown among Japanese young employees in their twenties and thirties and discuss the characteristics of their depressive state in terms of social backgrounds.

Recent state on mental health of young employees in Japan

In recent years, some statistics showed that cases of mental disorders in companies are increasing in Japan, especially among the employees in their thirties. The suicide rate also has been increasing among them.

Clinically, they often show depressive state. With their self-centered tendency, they often blame others. As they try to avoid talking with others, they sent e-mails even to their colleagues sitting in front of them in their office. Their interpersonal relations with other employees tend to be very superficial and limited. Their depressive state looks more like that of adjustment disorder than that of typical depression. They often want to see a doctor and request him/her medical certificates to get official sick leave.

The social background

Born between 1970 and 1984, they were called "ice-age generation to get job" After graduating from university or high school, they had hard time to find employment due to business recession from the early 1990s in Japan.

Soon after this business recession began, working conditions in Japan underwent striking changes. As international and domestic competition became fiercer, most Japanese companies restructured, down-sized and many lay-offs took place. Instead of hiring full-time employees, companies began recruiting part-timers and outsourced workers. Since many companies cannot afford to give training programs to new employees, some of newcomers had a difficulty to get used to their workplace.

Discussion

Some new types of depressive state, which are totally different from Typus Melancholicus (Tellenbach.H), have been reported among young adults during these several decades in Japan. With the business recession today, it seems that the new types of depressive state become more common and widely observed among young employees. The business recession in Japan seemed to come to an end and employment condition got better since 2005. But it was temporary. The subprime lending problem, however, caused global business recession in 2008.

Further studies are necessary if the new type of depressive state observed worldwide among young employees.

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"Hikikomori" or social withdrawal afflicted among Japanese young people

H. Kuramoto (*Japan*)

Introduction

Today countries all over the world are grappling with the problems faced by children and young people - the adults of the next generation. In developing countries, the pressing issues are how to get more children attending school, how to reduce the number of youngsters unable to read or write. Developed countries like Japan, on the

other hand, face different challenges - like lowering the school dropout rate and shoring up declining educational standards.

It is common knowledge that Japan in recent years has been beset by a dramatic increase in the number of young people who are reluctant to go to school and fail to attend class. Nor is the problem confined to compulsory education. Young people are dropping out of high school, and social withdrawal (Hikikomori) is becoming a long-term and in some cases even a chronic condition. Both show signs of developing into grave social problems.

In the U.S. and Europe, where research on school phobia and refusal to attend school go back to the 1930s, the problem has become less of a concern, while in Japan, more than 20 years behind, nonattendance at school is increasing at an explosive pace. Making matters worse are the bullying and school violence that blight the learning environment of Japan's schools.

Some who exhibit problem behavior as children, finding themselves unable to fit in anywhere as they grow older, sink into a condition of Hikikomori. In some cases it persists for years, growing worse to the point where the sufferers are unable to pursue any productive activity and so waste their precious youthful energy in idleness. It's a grim situation, with alarming implications for the future of our country.

Unfortunately, when it comes to understanding and devising measures to help these troubled young people, we're still at the trial-and-error stage, our resources are lamentably scanty. What we need to do is organize our thinking on this issue, get a grasp of the actual state of affairs, and at the same time hammer out some working principles to underlie a practical therapeutic approach.

The purpose of the research has been to reconsider the issue of the Hikikomori of young people with reference to diagnosis, treatment and prevention, and to build a foundation for an effective approach to the problem.

(1) The collection of existing literature on the subject – the study of as many as possible of the theses, books, scholarly publications and statistical material published in Japan and the West.

(2) Conceptual study: We endeavored to distinguish between psychopathologies associated with Hikikomori and other mental health problems (schizophrenia in particular), and, deepening the discussion regarding the linkage between Hikikomori and psychological trauma, school mental health problems (especially nonattendance at school) and industrial mental health problems (especially refusing to work), to present a coherent thesis.

(3) Surveys of conditions among the general public: To evaluate the true nature of Hikikomori among the general population, we conducted questionnaire surveys regarding cases dealt with by mental health welfare centers and public health centers nationwide.

(4) Evaluating responses to and results of treatment: We collected data concerning sufferers of Hikikomori who during the 1990s were involved in, or are at present involved in, the several facilities or programs affiliated with the Mental Health Center for Young People – the Kita-no-Maru Clinic, the Myogadani Club, the Hodogaya House, the Social Participation Support Program, and the Home Tutoring Program. Using a questionnaire we developed ourselves, we assessed and compared responses to and results of treatment.

The Mental Health Center for Young People and Kita-no-Maru clinic has since 1985 engaged in various types of consultations with and treatments for individuals suffering from Hikikomori. It is our hope that our research will be useful in Japan and abroad as an empirical and scientific approach to the problem of Hikikomori.

Conclusion

Between December 1999 and May 2000 a series of shocking crimes committed by youngsters said to be suffering from Hikikomori drew the attention of the mass media, whose commentary may have helped spread misunderstanding and prejudice regarding the condition. This occurred just as we were growing aware of the need to educate the public concerning the true nature of Hikikomori.

Meanwhile, with the media increasingly taking up the issue and the government and public agencies beginning to devise systematic approaches to it, public awareness at last started to grow. By then, however, a situation about which clinicians had been sounding alarm bells for over 20 years had grown serious indeed. It was attracting attention overseas as well - as a phenomenon that, like bullying and nonattendance at school, was characteristically and uniquely Japanese.

My report is summarized as follows:

A Concept of Hikikomori, introduces the relevant Japanese and foreign research and literature, discussing it from various and wide-ranging viewpoints, showing how far we've come

and what remains to be considered regarding questions such as the characteristic psychopathology of Hikikomori, nosological discussion on the differential diagnosis from schizophrenia. How is it connected to the traumas resulting from child abuse or bullying? What is its psychological relation to school mental health (with particular reference to refusal to attend school) and industrial mental health (with particular reference to refusal to work)?

The True Nature of Hikikomori, reports the results of a survey of public health centers and mental health and welfare centers nationwide, the first of its kind, conducted with the cooperation with the Ministry of Health, Welfare and Labor. This covers points such as: the number of consultations regarding non-psychotic Hikikomori, problem behavior related to Hikikomori (domestic violence, suicide, anti-social behavior), ages of consultation and duration of Hikikomori, work backgrounds (jobs, school refusal), ways of referral, day care and group activities, measures and consultations with respect to families, problems regarding support, and matters for future consideration. On May 8, 2001 the Ministry of Health, Welfare and Labor released a manual of guidelines entitled Hikikomori. This was distributed to mental health and welfare centers and public health centers and local governments across the country as reference material on how to respond to and treat Hikikomori.

Treatment of Hikikomori calls for a varied and comprehensive approach. In typical cases, one-on-one counseling, first for family members and then for the patient, should proceed in a calm, unhurried, courteous manner, gradually unfolding to include live-in treatment, the young people's Club, and so on. The subject is encouraged to participate in group activities, but on no account should the subject be pressured into returning into society before he or she is ready. As the subject grows accustomed to the programs, he or she is urged to adapt further to society through society participation support programs. As the need arises, as in the home consultation and home tutor-advisor programs, staffers can visit subjects at home, or communicate with them by telephone or fax or letter or via the Internet.

Note

This report is based on a research paper, funded by a 1999 grant from the Toyota Foundation and titled "Empirical Research Regarding the Present State, Origin and Treatment of Hikikomori among Young People"(Research subject: Mental Health Center for Young People; Research director: Hidehiko Kuramoto), which was revised to be published by Hon-no-Mori Shuppan in 2002 entitled "Shakai teki hikikomori he no enjo" and was translated into English in 2006 entitled "Hikikomori: understanding and treating the phenomenon of social withdrawal by Japanese youngsters" (still not in press).

Mental troubles of Japanese office workers and their families in France

H. Ota (*Japan*)

Between the 01/01/1985 and the 31/12/2008, for 24 years, we treated 2155 Japanese peoples in France and Europe (580 males, 1575 females). Among those 2155 cases, 3 groups account a majority: Students/ Researchers & their families (25%), Office workers & their families (21%) and International couples & their families (20%). In this congress, we chose the group of 445 Office workers & their families because of remarkable mental health difficulties of their family members rather than the office workers themselves.

Among the 445 cases, Office workers account only 141 (32%). Comparing with this, their wives account 184 (41%). When their children's cases (120, 27%) are added, more almost 70% are occupied by their families. Because of this amazed result, we will have to warn the necessity of mental health plan for the families of office workers.

Concerning the detail of mental disorders of 141 Office workers, Depressive state is in the majority (45%), and Anxiety disorders follow (38%). In 184 wives' cases, Anxiety disorders account a majority (51%), and Depressive state follow (33%). In any way, we need to notice that these two mental difficulties will be the most important elements in mental health plan of Office workers & their wives. The 120 children's cases are too various to cull the prospects to 3 or 4 disorders: Anxiety/Depressive disorders (30%), Mixed disorders of conduit & Emotion (18%), School adjustment disorders (12%), Pervasive Developmental Disorders (7%), Developmental disorders of Speech & Language (7%), Borderline personality disorder (7%), etc.

We can cite lots of risk factors for mental health of Office workers & their families. For example, mismatching with the new post of duty or long working hours are indeed grave risk factors for Office workers. In case of their wives, difficulties with other Japanese wives or loneliness are indeed serious risk factors when their husbands are absent. But we think that "Level of language and communication skills" may be one the most important factors. More precisely speaking, "Communication skills" is the key factor for cultural and social adjustments, because cultural chock is essentially related in gaps of "communication codes" between different cultures.

The present state of the second generation of the newcomers from abroad in Japan

M. Uemoto (*Japan*)

Introduction

In Japan, in the wake of recent augmentation of the number of foreign immigrants, the second generation of immigrants, the children and the adolescents who accompanied their parents from their country of origin or who were born in Japan, have been increased rapidly. Often the offspring along with their families find themselves in economic and、social difficulties. In addition the second generation is required to adapt to their new culture and the language. This is no easy task for them to achieve as it is made more difficult by the fact that Japan has very little experience in how to integrate foreigners into its society.

We undertook to investigate the actual situation of second generation immigrants including their mental state and the stress they feel

Object

Students belonging to junior high schools of KOBE City whose parents settled in Japan after 1980

Method

Participants were interviewed using a structured approach to determine the socioeconomic status of each family. Also, to determine their ability to use the Japanese language, paternal language, socio-cultural adaptation of family and scholastic achievements. Stress and Mental state of the participants were evaluated using the Birleson Depression Self Rating Scale for Children (DSRSC) and Modified Health Checkups for High-School Students.Interviews were conducted in Japanese, however, in the case of language barriers an interpreter assisted.

Results

Some 27 students and their parents consented to the investigation. Almost all of them expressed their will to remain in Japan. The mean score of DSRSC was 12.0: 26% of the participants showed higher scores than the cut off points of 16. These results were almost the same with that of the Japanese students which were higher than the results in occidental countries. There was no difference between grades, and between sexes. The item about intra familial communication had a strong relation with total depressive score.

The mean total score of Modified Health Checkups about tress and anxiety was similar to that of the Japanese students. However, Chosen items were different. Japanese students had a tendency to items relating to study and grade, the foreigners chose items relating to human relationship and communication. The foreign students with higher capacity of the Japanese language felt stronger stress from tension when in front of other person.

Interviews also showed language, communications and cultural transition were important problems for each family.

Note

This research are funded by a grant from the Toyota Foundation

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Standard Symposium (SS-IV-18)
Migration and Children

Chair: J. Achotegui (*Spain*); Cochair: Y. Abe (*Japan*)

Study of the migratory stress in child and adolescent population in Spain

D. Espeso (*Spain*)

This presentation raises the concept of the chronic and multiple stress ("Ulysses Syndrome") referred to the child and adolescent immigrant population.

The stress to which we referred has proper characteristics with a loss of control over the stressors.

It is very important to promote the resilience and the social capital in our therapeutic interventions. In this way we try to diminish the high vulnerability so to avoid the development of a severe mental disorder.

The subjective sense of Latin youths´ whose families sought counselling psychologist in Japan

D.S. Oda (*Japan*)

The present article has the objective to reflect Latin youths' subjective senses, whose families sought NPO SABJA´s (Non Profit Organization Service of Assistance for Brazilians in Japan) counseling psychologist.

According to González Rey (2003), the subjective sense is a complex configuration between emotions and symbolic processes, experienced in singular form in different situations and moments in the life of a person.

The methodology used was the qualitative epistemology of González Rey (1997) allowing investigation of subjective sense processes inside a determined historical-social, complex, pluri-determined, irregular and singular context.

All the information was organized and analyzed as case studies, therefore, the Conversational Systems of González Rey was adopted to permit the researcher to integrate natural dynamic of conversation with what I researched.

Moreover, the instrument of Complement of Phrases, by the same author, was applied with the purpose to decentralize the intentionality of the subject of research.

In other words, it tries to extend the possibility of indicators in the production of sense.

To elaborate this article, three Latin youths who looked for psychological service in NPO SABJA, were selected, as it was mentioned previously,.

The results of analyses demonstrated that these youth presented high anxiety and low self-esteem which could be observed in the speeches as in behavior disturbance, such as trichotilomanie, compulsion for cellular and social phobia.

The details of these case studies will be discussed during the symposium Migration and Children.

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Feelings of loss in Latin American children living in Japan. As seen by the Ulysses Scale

N. Tanaka (*Japan*)

Migration as defined by León and Rebeca Grinberg "is not an isolated traumatic experience" but "cumulative traumas and tension traumas in which the subject's reactions are not always expressed or visible, but the effects of such trauma run deep and long".

Whereas the experience of migration might be stressful both for adults and children, in the latter it may be more stressful as it is not an action out of their decision, and moreover, their parents themselves who are the source of support may not function as well because, they also are under the stress of having to adapt to the new environment.

In order to study the effects of migration in Latin American children whose parents came to Japan for work purposes, students in a school teaching in Spanish and Portuguese were given the PSI, an inventory measuring children's stress response, stressors, and perceived social support, aside a simplified version of the Ulysses scale for self-report evaluating the sense of loss as regarding to: 1) family members left in home country, 2) language spoken, 3) habits, food, festivities, 4) scenery, climate and colours, 5)life style and position, 6) group to which one belonged, 7) health and life conditions. Correlations between PSI items and the Ulysses scale were evaluated by non-parametric tests.

The subjects were 52 Brazilian and 24 Peruvian students, 28 females and 48 males.

The results showed significant correlation between sense of loss regarding family members and sadness, feeling annoyed, feeling good in the mornings, appetite, and feeling understood by classmates, indicating depressive feelings.

Sense of loss of the language was significantly correlated to downhearted. Sense of loss of habits, and food was correlated with feeling annoyed, feeling father's and teacher's support.

Sense of loss of the scenery was significantly correlated to insomnia, feeling like crying.

Loss of former life style and position showed correlations with appetite, and nightmares.

Loss of group belonging was significantly correlated to insomnia, nightmares, and support from classmates. Sense of loss in health and life conditions was correlated significantly with heaviness, laziness, and apathy. The results, which will be discussed during the symposium, indicate that children are affected by the experience of migration.

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Transcultural stress of Latin American workers in Japan

Y. Abe (*Japan*)

Today, 2.150.000 foreigners, that is, 1.8% of the total Japanese population live in Japan, and 400.000 are Latin American migrant workers. Stresses from immigration are supposed to differ according to the surrounding societal environment. Foreigners staying in Japan have various residential statuses, such as workers, spouses of international marriages, refugees, students, ethnic Korean and Chinese permanent residents, and visitors. Generally, the following are considered to be transcultural stressors: 1) life with a different culture and language, 2) different customs and life style, 3) trouble in interpersonal communication, 4) troubles at work due to the lack of communication, 5) unemployment and financial problems, 6) communication gap between parents and children, 7) maladaptation to school, 8) anxiety about health, 9) anxiety about the family left in their home country, 10) anxiety about the future.

The relation between the factors for mental disorders and transcultural stress has not been researched in Japan as much as in western countries because foreign residents in Japan are only under 2% of the total population. As it is considered that transcultural stress differs

depending on residential status, this study investigated the nature of transcultural stress of Latin American workers in Japan.

We investigated the types of stress that triggered mental disorders and the diagnosis of new Latin American patients who had consulted a multicultural mental clinic in Tokyo between March, 2006 and February, 2009. During this period, 233 Latin Americans received treatment at this clinic; 77 of them were males and 156 of them were females, therefore the patients were predominantly female. As concerning the period of stay, 60% of them had stayed in Japan for more than 10 years. Their nationalities were: Peruvian (104 persons),Brazilian (88 persons), Colombian (22 persons), aside of Chilean, Mexican, and Argentinian in less numbers.

Most of the stressors leading to mental disorders were: familial problems (57), problems concerned with work (27), interpersonal troubles (24), cultural problems (20), drug problems (9), health-related problems (8), and school problems of their children (4). Moreover, there were 60 patients without any obvious cause for mental disorder. The diagnosis of these patients was neurosis (112), affective disorders (87), schizophrenia (23), drug addiction (8), and others (3).

It was observed that matrimonial conflict was the main familial problem due to mutual difference in the speed and style for adaptation to a new culture. Problems at work were misunderstanding with their boss and colleagues due to language and communication problems. Most interpersonal troubles were with their neighbors and their compatriots, therefore it could be observed that cultural conflict comes from difference in language, custom and life style. It was also seen that as compared to Japanese, more Latin American patients suffer from mental disorders due to drug consumption.

The results showed that transcultural stress more often leads to affective disorders and panic disorders than to other mental disorders. Finally, Achotegui indicated that Ulisses syndrome is the characteristic symptom of illegal immigrants.In our research, only 2 patients who had illegal status and Ulisses syndrome was identified in one of them.

Standard Symposium (SS-IV-19)

Culture, Disasters and Mental Health

Chair: R. Crupi (*USA*); Cochair: J.M. Havenaar (*The Netherlands*)

Cultural Aspect in Disaster Relief

R. Crupi (*USA*)

Purpose

Mental health is recognized to be a core public health concern in disasters. The inability of victims to adjust psychologically and the stresses placed on community resources can result in more disabilities than the physical consequences of a disaster. Disasters have the potential to overwhelm the normal coping mechanisms of individuals and communities. Ethnic disparities in the provision of mental health care are well documented.

Materials and Methods

The MediSys Health Network (Flushing Hospital Medical Center, Jamaica Hospital Medical Center, Brookdale University Hospital Medical Center) located in New York City, New York has had extensive experience in providing post disaster mental health interventions to culturally diverse communities. The experience of the MediSys Health Network's response to the TWA Flight 800 crash in 1996, Egypt Air Flight 990 crash in 1999, the World Trade Center Attack, American Airlines 587 crash and anthrax attacks in 2001, and Hurricane Katrina in 2005 provide lessons for providing culturally appropriate care.

Results

Ethnicity and culture influence mental health care on the need for help, the availability and accessibility of help and on help-seeking comfort (stigma, mistrust). Community needs should be addressed early and often. Interventions ought to be guided by careful preparation that takes into account the cultural setting, community resources, local perceptions of needs and problems and perceived causes of these problems and ways of coping. In culturally diverse communities, mental health services must be easily accessible, validate and normalize distress and health seeking, and value interdependence as well as independence as an appropriate developmental goal.

In order to be effective, post disaster interventions should take advantage of community partnerships to provide for community-based mental health care to reduce stigma and mistrust and encourage community action. Community resources include local health providers, traditional healers, social and religious organizations, and respected leaders. Interventions should give greater attention to socially engaged emotions and functioning as provided through "psychological first aid" that aims to establish safety, emotional and social support and to ensure that basic needs are met. Mental health providers should be aware of culture-specific symptoms that may lead to underrecognition or misidentification of psychological distress. Clinicians must learn to decode the meaning of somatic and dissociative symptoms to be understood as a language of distress with interpersonal and wider social meanings. Cross cultural mental health services are more likely to succeed if they address co-morbidities, integrate care for both physical and mental disorders, have linkages with other services and are staffed by bilingual mental health providers.

Conclusions

Post disaster mental health interventions must be culturally responsive in order to lessen the barriers that contribute to disparities in care. Effective collaboration between mental health agencies and the local resources of affected communities must occur if the necessary framework for a culturally competent response is to be achieved.

Crisis intervention in Disaster Relief

A. Maffia (*USA*)

Over the last 15 years, mental health intervention in disaster relief has been an evolutionary process. It began with the utilization of the office-based intervention and counselling, but when proven to be ineffective, it moved towards a more external approach. As mental health professionals became more involved in disaster relief, intervention on behalf of the patients evolved from psychodynamic to a more practical approach which incorporated cognitive behavioural and debriefing elements. As mental health professionals continued to provide disaster relief, especially in the Oklahoma Bombing and the Attack of 911, the use of Psychological First Aid became the newest approach in dealing with the multiple crises and the subsequent disequilibrium experienced by all those who were affected by these disasters.

This presentation will address the origins and lessons learned from the disaster experiences that help formulate the Crisis Intervention and Disaster Relief model utilizing Psychological First Aid interventions. Mental health clinicians will learn how to use this model to provide culturally sensitive treatment to help these victims. The goals of this model are to provide safety, enhance connectedness, improve the flow of correct information, and promote self- efficacy, empowerment and hope. The physical, emotional and psychological wellbeing of children is always of particular concern in response to a disaster. Symptoms of emotional trauma and stress in school-aged children will be addressed. Compassion fatigue on the part of mental health professionals will also be addressed.

Long Term Challenges in Disaster Relief

D. Chen (*USA*)

Disaster, according to the Webster's College Dictionary is defined as "a calamitous event, especially one occurring suddenly and causing great loss of life, damage, or hardship, as a flood, airplane crash, or business failure." It could be a natural disaster like Hurricane Katrina in the U.S. in 2005, or a manmade disaster like the 911 attack of New York City in 2001. Both disasters caused great loss of life, physical damage, and mental illness for people who were either directly or indirectly involved. The city of New Orleans is still struggling 4 years after Hurricane Katrina in all areas of recovery. As of May 2008, the overall recovery effort for the city of New Orleans was graded D+, with F considered as failing grade in the areas of economy, utilities, health, housing and public education. According to the findings from Project Liberty, the New York's Crisis Counseling Program Created in the aftermath of September 11, 2001, the terrorist attack had substantial long-term impact on mental health.

As part of the Flushing Hospital Medical Center's multidisciplinary disaster response team, the mental health clinicians provided culturally sensitive crisis intervention in English, Spanish, Chinese, Korean, and Indian on September 11, 2001 and thereafter. They have also provided long term follow up care to patients in need. Specifically, this writer treated a total of 29 patients for PTSD during the acute phase. Treatment included the combination of crisis intervention, supportive therapy, cognitive therapy, and healthy lifestyle with or without medication management. Case management services were also provided to the patients for local and federal aid, including insurance coverage, unemployment benefit, and housing programs. Fifty one percent of the patients chose to terminate the treatment on their own after their symptoms were improved. Seven percent of them ended their treatment as part of the treatment plan agreed upon by both the clinician and the patient. Forty one percent still receive treatment including medication today, and thirty percent of those who still receive treatment are back to work. The following vignette illustrates the long term challenges in mental health care when working with victims of the September 11 attack:

Prior to the September 11 attack in 2001, Y.T. was a 52 years old married Chinese female without a psychiatric history. She was living with her husband and an adult son in Queens, New York and working as a housekeeper in the one of the buildings close to the World Trade Center. She was cleaning rooms on the 21st floor when the attack happened. She witnessed the airplanes crash into the towers and escaped the building she was in. When she was referred to the mental health clinic at Flushing Hospital in October 2001, I diagnosed her with PTSD. With treatment, her PTSD symptoms improved and she was able to go back to work at the same place in ground zero eight months later. Y.T. was doing well until the 2003 New York City Blackout, during which she had to repeat the same escape route with tens of thousands of people rushing out of the building, running towards uptown, crossing over the Queens-Borough Bridge and eventually to home in Queens. She was able to finish the route after 7 hours on September 11, 2001. But she collapsed twice on the way because of severe shaking and diarrhoea in 2003. No ambulance was available amidst the panic and chaos. It took her 10 hours to walk home from Manhattan to Queens. As a result, her symptoms worsened, and I diagnosed her with Major Depression in addition to PTSD. I prescribed three more medications in order to control her symptoms. It took 6 months longer than the first time to stabilize her. Y.T. was re-traumatized for the third time when people were ordered to evacuate the building in 2004 due to a fire of unknown cause in the basement of the building. Again, she had episodes of severe shaking, vomiting, and diarrhoea in addition to re-emerged PTSD and mood symptoms. Since then, her PTSD and depressive symptoms have never been able to be totally under control. Her gastric symptoms have also persisted. Because of the bureaucratic health system, an endoscopy was only scheduled recently for August 2009. More somatic symptoms have emerged including headache, dizziness, and body ache. Her relationship with her husband worsened, she is more socially isolated, is not interested in pleasurable activities, and finds it more difficult to finish assignment at work. In 2001, she went to court to fight for mental health coverage because her insurance company refused to do so. Recently she received thousands of dollars of bills from a collection agency and learned that the coverage for her mental health care was terminated again. Y. T. has notified the writer that she will not continue her treatment until her coverage resumes since she is not able to pay the bills on her own.

The above case illustrates the long-term challenges in disaster relief, such as delivering on-going health assessment and treatment, preventing re-traumatization, accessing treatment, obtaining insurance coverage. The Project Liberty findings indicated that broadening the continuum of care with public funding to disaster victims was necessary. The project ended in 2003, but people's struggles continue. Therefore, we urge federal and local government to assess the long-term challenges in disaster relief and provide continuum care to the victims.

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Mental health problems following the enschede fireworks disaster. A naturalistic follow-up study on service use and outcome

E.O. Noorthoorn (*The Netherlands*), J.M. Havenaar (*The Netherlands*), Y. van Rood (*The Netherlands*), W.A.H.J. Van Stiphout (*The Netherlands*)

Objective

In the year 2000 a fireworks deposit situated in the middle of a residential area exploded, killing twenty-two people, injuring about a thousand and devastating four hundred houses in the centre of Enschede, a provincial town in the eastern part of the Netherlands. This study documents the number of people seeking help for disaster-related psychological problems following. It describes their diagnostic characteristics, the interventions they received and the results of these interventions.

Method

In the first week after the explosion, the regional mental health care institute organized a special team to provide evidence-based therapies for people who suffered from disaster-related mental health problems. This disaster support team was set up as a low-threshold service to which people could be referred without a waiting list. Contact registration data from this specialized disaster relief service and the medical charts of all patients who visited the service between May 13th, 2000 and June 1st, 2004 were systematically coded. Patients who received more than eight treatment sessions for disaster related mental health problems were interviewed with the Comprehensive International Diagnostic Interview (CIDI) and other questionnaires. Multiple regression analyses were carried out to examine determinants of service use and treatment outcome.

Results

Within the probably exposed population cumulative contact-incidence for disaster-related mental health problems over the 4-year observation period was approximately 10% which amounts to an extra influx of to the mental health services of 5.7%. People from ethnic minority groups were more likely to seek care than could be expected on the basis of population data and on data on service use for other mental health problems. As could be expected, PTSD was the most common clinical diagnosis (53%). However, based on the CIDI diagnoses depression was the most common disorder (58%). Overall, the recovery rate was about 50% in terms of clinical judgment, and between 60% and 70% in terms of a 'healthy' last measurement on the questionnaires. Patients from ethnic minorities had greater risk of drop-out from treatment and of poor treatment outcome on some but not all outcome measures.

Conclusions

Apart from people who sought support during the first few weeks after a disaster, the largest influx of patients with disaster-related mental health problems occurred after about a year and was limited in size. People from ethnic minorities are at greater risk of seeking help for posttraumatic psychopathology and of having poor treatment outcomes than native Dutch. Clinicians in specialized disaster services should be aware that in addition to PTSD other conditions, such as depression, anxiety, substance use and somatoform disorders are also quite common following disasters.

Standard Symposium (SS-IV-20)

Arts-Based Therapy & Research in Cultural Psychiatry. Cultural Traditions and Techniques

Chair: J. Arpin (*Switzerland*); Cochair: E. Colucci (*Italy/Australia*)

Stitching the pieces together. A visual arts inquiry

M. Eales (*Australia*)

In today's society, visual arts are generally seen as outside the realm of the medical sciences.

Art's ability to contribute so-called 'new knowledge' is often viewed with scepticism and mistrust because of the use of symbols and metaphors, which can be misunderstood and difficult to interpret. That said however, art-based research 'has' the ability to explore issues and contribute to knowledge through engagement with the imagination. The multiplicity of art-based research practices express and communicate human experience through critical interpretation and contextualism in similar ways to storytelling. My practice and methodology for the installation 'Too few ladders' has been to try to understand suicide by creating a story imbedded within many stories through sewing together remnants of memory and personal artefacts to form a quilted tapestry of information. My work attempts to humanise the issues around suicide and allows for insight to occur from both macrocosmic and microcosmic perspectives.

In expressing lived experiences through art, my aim is to remind the audience (and myself) that we are more than just a body and a mind. Our humanness/soul/spirit also needs to be heard, nurtured and (re) considered both in academic research and in daily life.

Participants will learn to:

- Have a greater appreciation and understanding of arts-based research.
- Gain insights into how arts-based research can impact on an individual as a process of healing.
- Understand alternate ways of approaching research either as an individual or within an interdisciplinary collaboration.

Behind the canvas. The making of a history

J. Delachaux (*Switzerland*)

My artistic work has evolved around the life of three imaginary characters – two boys and a girl. They are technically made of plastic bones, plasticin skin and glass eyes. Vassili, Johan and Naïma, now 24 year-old, have been my models since they were 12. I paint their everyday life, staging them in various situations like live models and also like actors in situations that are always very realistic.

Examples as case studies: Naïma and Johan are musicians; they have issued four albums. Although fictive, this music production is real since I have indeed recorded it. Vassili was an autistic child; I once took him to a doctor who opened his skull and removed the stone of madness from his brain; now Vassili is healed. The doctor was a protagonist who participated in my project, pretending to perform an operation, which was documented (video and paintings).

This project expanded into using multimedia art forms and techniques, as I have kept on working around my characters' bodies and faces, allowing them to "grow up". I change their expressions and their looks, using photos, paintings and also writing. Naïma is currently writing a book herself. And we all practice music regularly.

Participants will learn to:

- Enter an artistic work where fictive characters are treated like case studies, through various narrative modes.
- Learn how a life history can be completely made up, from creation to montage.
- See possibilities of using such "character creating" in therapies, both in case-history making and in treatment.

Haridwar. A spiritual journey

E. Colucci (*Italy/Australia*)

Art can be a powerful tool for eliciting thinking and discussion (thus generating and gathering data) as well as a means to report/disseminate findings. In fact, the arts have been used for decades in research and practice and they are increasingly been used, also because of a counter-movement to the dominance of positivist epistemologies. However, the medical sciences are reticent towards embracing the arts in research, which as a result has seen limited use even in disciplines which deal with people's mental and existential problems (and that perhaps most could benefit from them), such as Psychiatry.

During her presentation, Colucci will illustrate the way in which arts, and film in particular, can be implemented to (re)present a research experience by showing a short-documentary from her latest fieldwork in India. This film provides an insight into her journey through the spiritual life of Haridwar (North India) and, in particular, into a University and ashram where Colucci is conducting research on spirituality. In Hindi, Haridwar stands for Dwar of Hari or Gateway to God. Haridwar, situated at the foothills of the Himalayas, is regarded as one of the seven holiest places in Hinduism. Hence, every year millions of pilgrims and devotees make their way here and perform ritualistic bathing on the banks of the river Ganga. This is in fact the opening scene, which shows the essential elements of the Ganga Aarti in Hardwar's Har-ki-Pauri: the diya pack (composed of flowers, lamp and incense), the fire, the sacred waters of the river Ganga and the sound of bells. From here the scene moves to the ashram Shantikunj and the DSVV University, both inspirations of Gurudev (Pandit Shriram Sharma Acharya). Every aspect of life in this unique University centers around spirituality and this short-documentary offers a snippet into the life of this community and the rituals and activities that take place here: from the laboratories and Ayurvedic garden in the Brahmavarchas Research Institute to the treatments in the Psycho-spiritual clinic and the yagyopathy (sacrificial fire) offered in remote villages. This is believed to have preventive and curative properties on several ailments while resulting also in spiritual attainment.

Participants will learn to:

- Increase their knowledge on arts-based research;
- Be exposed to a example of an amateur's use of film-documentary to complement more traditional ethnographic research methods;

Start questioning whether "scientific" papers are the only way to (re)present data and open-up to the idea that in some instances "there is much more said in an image then in 1000 words".

Masters of their conditions

J. Arpin (*Switzerland*)

The Masters of their conditions project explores how the human body is capable of learning through various methods, in particular that of traditional apprenticeship and codified learning. The author first examines how such training methods have allowed for ancient traditions to remain intact and active. Theatre anthropology and performance studies offer training methods that facilitate clinical applications in cultural psychiatry and medicine.

The project evolves towards further use of body and other communication media within traditional learning methods introduce enriching material and technique into the performance of narration – the case history making. Narration is a multimedia performance that requires the knowledge of masters who either reproduce traditional texts, or/and create innovative narrative forms. This clinically fits within narrative-based medicine in the context of a multicultural consultation.

This project is a work in progress; further steps are under construction. Clinical applications are predominant in the elaboration of body apprenticeship and multimedia narration.

[Arpin already presented such aspects of research and application in SSPC annual meetings in 2003 and 2007, with performers from India (bharata natyam dancer Sujatha Venkatesh) and the USA (multimedia artist Jan Gilbert), and in the form of live presentation-performances].

Participants will learn to:

- Explore traditions and techniques that consider body as a vehicle of culture, through various traditional modes and codified learning.
- Expand the case-history making into a multimedia performance, in languages other than medical and verbal.
- Create a sequence of actions in a research project, using clinical work to develop the patient/healer partnership.

Satellite Symposium (SatS-1)

The CareIf Vision of Young People - Health and Wellbeing. Resilience, Spirituality and Cultural Systems

A. Persaud (*UK*), N. Warfa (*UK*), K. Bhui (*UK*), S. Dein (*UK*)

The Centre for Applied Research and Evaluation - International Foundation (Careif) has been established to enhance the wellbeing of individuals & communities through sharing knowledge and understanding of their cultures and traditions in order to ensure that working practices and services have maximum impact and are suited to different cultures from across the world.

Careif made a significant contribution in the construction of the UK Government London 2012 Olympic and Paralympics' Games Health Plan through its own programme of work in collaboration with a number of partners in Public Health, Strategic Health Authority, the Dept of Health and other institutions. The Games were won in part on the benefits and health legacy to young people from diverse cultural, religious and racial background. It is acknowledged that the Careif's programme of activities, on Young People, Sports, Health and Wellbeing (Careif Olympic Generation Programme) represents a sustainable and impacting contribution towards delivering and securing a health 'legacy' both in the lead up to the Games and afterwards. The full programme includes work on personality disorder and ethnicity, cultural identity and health, khat use, youth crime, sport and well being, young people's surveys of health, culture and well being. Culture is broadly defined to include sport, art, spirituality and any other cultural practices that promote health and happiness.

This work builds the legacy sequentially, whilst working towards the World Association of Cultural Psychiatry (WACP) 3rd World Congress of Cultural Psychiatry which highlights the theme again of young people, their health and wellbeing. Careif will act as a local organiser for this meeting. The volume of work undertaken in the build up will be capitalised to sustain these activities following the Games.

Standard Symposium (SS-V-21)

Cultural Psychiatry in a Multicultural Society. Canadian Perspectives

Chair: L.J. Kirmayer (*Canada*); CoChair: H. T. Lo (*Canada*)

Culture and curriculum development. An integrative approach to resident education at the University of Toronto

H. T. Lo (*Canada*), L. Andermann (*Canada*)

As it is increasingly recognized that cultural competence is an essential quality for any practicing psychiatrist, postgraduate psychiatry training programs need to incorporate cultural competence training into their curricula. This presentation describes the unique approach to cultural competence training for residents being developed in the Department of Psychiatry, University of Toronto over the last few years. With a mindful, balanced emphasis on both generic and specific cultural competencies, a deliberate "integrative" approach is used. Learning objectives are derived from integrating the tripartite model of attitudes, knowledge and skills with the seven core competencies of a physician as defined by the CanMEDS roles framework. The learning objectives and teaching program is further integrated across different psychiatry subspecialties and across the successive years of residency (ICPC). Another unique strategy used to foster curricular and institutional change is the program's evaluation-driven emphasis, making use of insights from modern educational theories, including the concepts of formative feedback and blue-printing. It is proposed that these developments may lead to evidence that demonstrates the curriculum's effectiveness and ultimately its impact in healthcare.

Learning objectives.

At the end of this session participants will be able to:

- To gain a better understanding of strategies and challenges in the development of a cultural psychiatry curriculum
- To gain knowledge of the concepts of generic and specific cultural competence
- To be aware of the issues in evaluating outcomes of cultural competence education

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Being a "bicultural" psychotherapist. Challenges and rewards

K. Fung (*Canada*)

Culture is an important dimension in psychotherapy. Not only is a cultural understanding of patients necessary, it is equally important and no less challenging for therapists to become aware of their own culture's influences on their practice of psychotherapy. For psychotherapists who themselves are visible minorities, immigrants, or from non-dominant cultures, these influences may be especially salient, affecting how cases are conceptualize, therapeutic goals are set, and therapeutic techniques are employed. Specific transference and counter-transference issues may arise when the therapist and the patient's cultures differ. Some of these

interactions may facilitate or impede the course of therapy.

This workshop will explore these cultural influences and interactions, and discuss therapeutic strategies that may facilitate successful negotiation of them, avoiding possible therapeutic impasse and increasing the therapist's clinical effectiveness.

At the end of the workshop, attendees will be able to:

1. Describe how a therapist's own culture can influence the practice of therapy.
2. Discuss the advantages and disadvantages of being a "bicultural" psychotherapist.
3. Describe specific transference and counter-transference issues which may be encountered by "bicultural" psychotherapists.

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Cultural diversity in the work of Mental Health Commission of Canada

L.J. Kirmayer (*Canada*)

Cultural diversity presents challenges for the design and delivery of mental health services. Canada has a high level of cultural diversity with almost 20% of the population foreign-born. The official policy of multiculturalism suggests that cultural heritage should be respected and accommodated in mainstream settings. However, newcomers (including immigrants and refugees) and members of some established ethnocultural groups tend to under-utilize mental health services and may receive inappropriate or ineffective care. Culturally based ways of understanding and dealing with mental health problems play a central role in determining the use of mental health resources as well as clinicians' ability to provide effective treatment.

Given the high levels of diversity in Canadian communities, it is not always possible to have sufficient local expertise in the form of bilingual, bicultural practitioners or culture brokers. This presentation will review recent work on cultural diversity done for the Mental Health Commission of Canada. This work reviewed previous reports on multiculturalism and mental health and identified key issues for a National Strategy for Mental Health. The aim is to address the needs for members of ethnocultural communities, immigrants, refugees and Aboriginal peoples within a reformed mental health system. The geography and political organization of Canada precludes a single model and the high level of diversity makes ethnic matching of limited use. Multiculturalism advocates mainstreaming but this often results in neglect of cultural issues. This presentation will also describe a project funded by the Mental Health Commission to develop and evaluate a set of internet-based tools and networking strategies to facilitate multicultural mental health services. The objective is to make sound and relevant cultural information readily available to consumers, planners, and providers across Canada, including those in rural or remote settings, and to evaluate the use of these resources by end-users.

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Standard Symposium (SS-V-22)

Culture and Children Development. Resources and Criticism

Chair: G. Biondi (*Italy*); CoChair: M. Ascoli (*Italy/UK*)

Children in hospital. Two unknown worlds, two unknown systems. Role of the intercultural mediator

G. Biondi (*Italy*), S. Zacaria (*Italy*)

Ethnic disparities in health care are receiving increasing national attention from public health and medicine. A Children Hospital is a complex system with many subsystems.

In the last years, there was a strong immigration process in Italy that involved an increasingly high number of children.

The different cultural approaches of health care have created many problems not only on the linguistic side. No less important is the poor training of health professionals to accept a different way of responding to the clinical information and therapeutic indications.

The intercultural mediator (IM) make exchanges possible between people of different ethnicities, socio-cultural backgrounds like a bridge between immigrants children, parents and the hospital in order to promote health integration of the child and his family (as indirect effect to health prevention).

Our experiences demonstrates how the hospital staff has difficulty to understand the cultural complexity with foreigners that in different ways represent emotions and also affective and educational parent support.

The foreign parents perception in hospital is to be isolated, unaided. For them it is very challenging to understand the diagnosis, the therapeutic procedures and the clinical treatment. They don't understand the meaning of the words and the gestures of people around them, they don't know the cultural and social habits, the hospital organization, the rules, the times.

The isolation can be either a self-isolation or expulsion from others. The misunderstanding and mistrust can create a submerged or expressed conflict through a silent behavior opposition. We will illustrate the importance of the role of IM by highlighting some of the difficulties in daily care.

In his long hospitalization the child becomes able to understand and communicate in Italian; often he becomes the interpreter between his parents and the doctors and nurses. The risk is a that he can be exposed to many advices and he is likely to be informed but not prepared to clinical information. The IM has the opportunity to help parents prepare the child to the care procedures in respect of their cultural ways.

The difficulty to maintain a continuity in the relationship between the child, the parents and the staff is one of the most important problem that was reported for the IM intervention in our Hospital.

The effects of discontinuity are: a) communication difficulties between family-hospital staff-family; b) a different approach of various intercultural mediators; c) parents are forced to wait when the IM is not available.

Starting from this reflection it seems necessary to propose a cross cultural training to all those operating in the hospital system in order to decipher the meanings from which behavior is culturally marked and to ease a more challenged help of IM.

Infancy and crossculture. A nursery experience

M.F. Posa (*Italy*), M. Mira (*Italy*)

About 20 years ago emergency immigration demanded in Rome, as indeed all over our country, attention and support for foreign children and their families who were subjects particularly exposed to the risks of immigration which was not then so well structured but now is gradually taking shape in Italy.

The nursery Piccolo Mondo in Rome is one of the first experiences in this area. Since 1988 it has taken in more than 600 children whose parents come from 56 different countries. In Piccolo

Mondo the service for the rights of minors is concretely promoted from the realization of the full development of all their potentials to the preservation of the child's personal identity with the family unit in contrast with all those actions that put the developing wellbeing of the person at risk. Children of non-Italian origin live in a complex developing challenge in which is inherent opportunity as well as potential disadvantage. In the course of their development they have to face such added difficulties as to constitute, in some cases, conditions of specific psychological risks (crosscultural risks). These exceptional stressing events have, as their one common denominator, the loss of basic security in the context of development and all together determine a characteristic condition of fragility.

The good psychopedagogical practices allow the principle of the uniqueness of the person and the intercultural perspective of the development to become a reality, in the conviction that the support to growth constitutes a primary prevention of psychic disorder or apparent psychopathology that can manifest itself in the course of life.

It is necessary, therefore, that all those involved, on different levels, in the process of care, equip themselves with specific knowledge and competence aimed to remove the obstacles to growth in the ethnocentric culture and to favour, instead, a crosscultural approach in their assistance relations.

Hospital as home. Analysis of an experience. A case report

P. Tabarini (*Italy*), G. Biondi (*Italy*)

This work will take into exam the psychological development of a child, now adult (18 years old), of Moroccan origins, hospitalized for an intestinal intestinal pseudocstruction in our hospital when he was four years old and is still an in-patient.

The child's parents were never very present, he grew up with the support of all the hospital staff that became his caregivers during his growth.

One of the aims of the present paper is to emphasize how the commitment of the entire group towards the child allowed him to maintain, in time, a psychological integrity in spite of the many operations, the many medications undergone , his loneliness and his fear of dying.

His body was and still is invaded by tubes, stymie and scars.

Another aim will be to notice the contribution of psychotherapy realized in the hospital with him. The boy has elaborated his illness, the separation from his family, and he has adapted his Moroccan origin to the Italian way of life.

Moreover psychotherapy has allowed him to face the fear connected to his medical problems and to the possible intestine transplant. All his problems: his fear of death, the separation from his parents, the relationships with the different caregivers have generated emotional problems.

Moreover the anger for his living in hospital, the new complications such as the interruption of mouth feeding; the life of a chronic patient in hospital, and now of an adolescent that is facing life out side the hospital.

Standard Symposium (SS-V-23)
Culturally Sensitive Mental Health Care in Rotterdam, The Netherlands

Chair: P. van Loon (*The Netherlands*); CoChair: R. Borra (*The Netherlands*)

Psychiatric care and migrants

P. van Loon (*The Netherlands*)

The effects of migration both to Europe and the rest of the world and its implications for mental health services cannot be ignored. Increased awareness of the influence of culture in psychiatric practice is essential in order to provide optimal mental health care. Direct application of standard treatment approaches whether psychotherapeutic or even in the realm of psychopharmacology will often not fit the bill and will require modification if we are to provide efficient and appropriate care.

In this presentation issues to be discussed for culturally sensitive mental health care include the role of communication factors (ethnicity of staff, cultural mediators, the role of interpreters), the search for valid and reliable cross-cultural psychological assessment instruments, the cultural assessment in formulating cultural identity and the manifestation of illness, knowledge and the application of alternative methods in the Rotterdam context. The role of the social context and factors such as discrimination and stigma in the utilization of services will also be discussed. Attention will be given to the issue of globalization.

Culturally sensitive diagnostic instruments

R. Borra (*The Netherlands*)

To provide efficient and appropriate mental health care standard diagnostic instruments need modification. The cultural interview, developed to be helpful in the process of making a cultural formulation of a patient, is discussed. Also, the bi-lingual diagnostic interview for depression and anxiety in immigrant Turkish women, developed during the research "Depression in Turkish women" can illustrate how to make instruments more culturally sensitive.

Chronic pain in transcultural perspective

L. Bamburac (*The Netherlands*)

During last few years there is a growing attention among mental health professionals in Netherlands for chronic pain and other bodily symptoms that lack clear identifiable etiologies. There is also growing sensibility for migrant population suffering from this problem. In cooperation between RIAGG Rijnmond Outpatient Psychiatric Services and Rijndam Rehabiliation Center a comprehensive program was developed specially designed for non-western patients, the first such program targeting non-western population in the Netherlands.

The program is based upon cognitive-behavioral principles and given in a group setting. The goal is to enable the patient to understand and accept the pain, to gain mastery over it, to

refine cognitive patterns and coping strategies, to reduce affective distress and to improve adaptive functioning and quality of life. Part of the program is reserved for relaxation techniques and informing about medication and sleeping hygiene. The pilot group consisted of women of Turkish descent. The content of the program was adapted to the cultural background and level of education of the group, all written material was translated and an interpreter was involved all the time. The team is interdisciplinary, consisting of psychiatrist, physiatrist, ergo-therapist, physiotherapist, psychologist and psychiatric nurse. In this presentation we would like to present the program as well as its first results.

We would like also to address difficulties and to discuss whether such a program could be applied to non-western patients.

Standard Symposium (SS-V-24)

Dawn of Multiculturalism. Change in Japanese Society

Chair: F. Noda (*Japan*); Cochair: T. Akiyama (*Japan*)

Pathological voyage

I. Asai (*Japan*)

Objective

Whether or not to give permission to patients with mental disorders to go abroad can be problematic for psychiatrists. A lack of sufficient research in this specific area is a strong cause for the dilemma. Therefore, since last year, several investigations into this problem were planned. This is the first pilot study to gather data on this problem.

This research seeks to determine whether or not going abroad for patients with mental disorders poses any risk of recurrence or worsening of their conditions. Furthermore, if the risk of recurrence or worsening of condition is high, additional research must be conducted to contribute to the body of knowledge and identify methods for reduction of that risk.

Method

At a private clinic five psychiatrists conducted studies on two different research groups. The first group consisted of 30 foreigners who have suffered from mental illness in their respective countries prior to arrival in Japan. The second group also consisted of 30 foreigners who were diagnosed as suffering from mental illnesses for the first time in their lives, after their arrival to Japan. Both groups have the same socio-demographic features and mental disorders with the same level of severity. The psychiatrists heard their histories and diagnosed them as DSM-IVTR and ICD-10. Next, for the first group, the degree of change in disorder severity in patients' respective home countries and after arrival in Japan was determined. After this process the patients were given treatment and their conditions were reassessed and compared with those of their home countries. After treatment, the degree of change of disorder severity was also determined for patients of the second group.

Results

For the first group all of the patients showed some symptoms at their first interview, 25% were in a remittance stage and 75% already had some symptoms at home (prior to coming to Japan). This suggests that the 25% of the remitted patients' conditions worsened after visiting Japan. Overall in the first group, 46% of the patients' conditions worsened after arriving in Japan and 54% of them remained stable. After the treatments by the psychiatric team 82% of the patients experienced higher levels of improvement than they had in their home countries. This recovery ratio is almost the same as that of the second group of patients who had their on-set in Japan.

Conclusion

For patients with mental disorders, going abroad poses a rather high risk of both recurrence and increase in disorder severity. However, if the patients receive proper treatment abroad, it is also possible for their conditions to improve (even more than those at home in Japan). It is best for psychiatrists to advise patients going abroad to seek out a local psychiatrist and continue treatment. Their voyage may improve their mental health.

Japan's first experience to accept hundreds of foreign nurses. Its scheme and current problems

Y. Kawaguchi (*Japan*), Y.O. Hirano (*Japan*), S. Ohno (*Japan*)

Introducing Nurse and Certified Caregivers to Japan under EPA

Japan and the Philippines signed an Economic Partnership Agreement (EPA) in September 2006. In this agreement, Japan would accept up to 1000 Filipino nationals, of which 400 were nurses and 600 were caregivers. Furthermore, in August 2007, Japan and Indonesia concluded their EPA that allows Indonesia to send the same maximum number of nurses and caregivers to Japan. Although there are some distinctive features in this agreement, it follows the Philippine's model in principle.

In August 2008, the first batch of nurses and certified caregiver candidates from Indonesia arrived in Japan. Indonesian nurse candidates were then assigned to various hospitals in February of the following year after their 6-month Japanese language training, and began to work as "nurse aids", because they are not recognized as registered nurses before they are able to pass the nursing board examination in Japanese. In May 2009, the first group of nurse and certified caregiver candidates from the Philippines (over 270) arrived in Japan and today they are studying under the Japanese language training program.

Since this is the first time for Japan to accept a number of foreign nurses and caregivers, it has caused various social problems in the country. Our study discusses those problems and issues based on our study findings.

Schemes on Inbound Nurses from Overseas

In this study, we focus on issues and implications of foreign nurses. Indonesian candidates should have a college degree and 2-year work experience (3-year experience for Filipino candidates) before their arrival in Japan. If they can pass the Japanese national nursing exam in Japanese after 6-month Japanese language study and a certain period of nursing training at the hospital, they will be permitted to work as registered nurses in Japan. They can stay in Japan as "nurse candidates" or "trainees" up to 3 years, and if they do not pass the exam within the 3 years, they have no choice but to return to their country. Those who pass the exam and acquire the nursing license will be able to continue to stay in Japan with a renewable 'special activity visa - Nurse'.

Outlines of the Study

< Study 1 >

Focus group discussions with professional nurses, nursing students, and university faculty members from the field of nursing in the Philippines (around 70 in Manila and Davao in September 2007) and Indonesia (around 50 in Jakarta and Bandung in June 2008)

We examined how Japan's EPAs with Indonesian and the Philippines were evaluated by the people concerned before Japan began to accept foreign nurses under its EPAs. As a result, many Indonesians expressed their desire to work in Japan, whereas fewer Filipinos expressed the same desire. The reason for this is that Filipino people do not recognize the Japan-Philippine EPA scheme as an attractive one at all. Moreover, both peoples indicated various negative opinions saying, for instance, "It is not very appealing to work in Japan due to the obligation of passing the national board examination in the Japanese language", "There is no workplace in Japan where we can use our expertise obtained in our country", or "Since we cannot work as registered nurses before obtaining the nurse license in Japan, we may just end up doing supplementary work. So there will be no guarantee we get what we deserve, based on our profession."

< Study 2 >

The nationwide questionnaire survey on employment of foreign nurses in Japan

Our survey was done in February 2008 – just before introduction of foreign (Indonesian) nurse into Japan. 1604 big and medium-sized hospitals, with more than 300 beds, located throughout Japan were the subjects of this survey. The response rate was 34.1%. 83.0% of all respondents (541 hospitals) expressed their wishes to accept

nurses from abroad, and 46.1% of them expressed their desire to hire foreign nurses – which certainly showed a great interest in employment of foreign nurses. Many hospitals chose "to resolve a shortage of nurses (64.7%)" as the major reason for this, while a considerable number of hospitals explained their reason such as "contribution to international exchanges (54.6%)." and "activation of human relation in the hospital (31.3%)." The results suggest that most hospitals may not have enough time and manpower required for training foreign nurses whose nursing and/or communication skills are not yet known in Japan. 33.6% of them answered "no idea" for acceptance of foreign nurses most probably due to the lack of information provided by the Japanese government.

< Study 3 >

Interviews with Indonesian nurse candidates in Japan and Japanese staff working with them

This survey has been conducted in Fukuoka Prefecture since May 2009. It reveals that both foreign nurse candidates and Japanese hospital staffs have made great efforts to prepare the national nursing exam. As predicted before their arrival in Japan, the biggest problem at their workplace is the Japanese language. Although most Indonesian candidates have developed their speaking ability in Japanese, they still have faced with difficulties in reading and writing Japanese words, particularly kanji (Chinese character) the highest hurdle for their language learning. Because of this, many of them can not understand the meanings of some exam questions. Those candidates are concerned that they may not be able to pass the exam during their stay in Japan (up to 3 years). Training and learning system varies from hospital to hospital. Consequently, many nurse candidates have grown their frustration and felt pessimistically that they may not be able to achieve their goals to work as registered nurses of Japan in the future.

Conclusion

Before Indonesian and Filipino nurse candidates arrived in Japan most Japanese hospitals accepting those candidates were provided limited information of medical and nursing situation in these two countries by the Japanese government. Soon after those candidates were assigned to the hospitals, a number of issues such as their limited language ability came to the surface. Many employers of those hospitals have often expressed their frustration by saying, "The Japanese government has nothing to help us. It just makes us shoulder all responsibility for their study to pass the exam." The Japanese government has not yet showed us a future vision clearly regarding this matter. We suggest that the government should work on their language and examination problems without delay, and make foreign nurses significantly contribute to overcoming a shortage of Japanese nurses at the hospital, which has become more serious year after year in the most aging society in the world. The government also should reexamine the whole scheme of EPA for benefiting peoples of sending and receiving countries.

Note

(The above surveys were done as part of Kyushu University's Program and Project to Form a Hub of Education and Research, "A Global Sociological Study on Japan's Opening of Its Labor Market Particularly in the Fields of Caregiving and Nursing [Representative: Dr. Shun Ohno, Director of Kyushu University Asia Center]).

Standard Symposium (SS-V-25)

The Cultural Origins of Anorexia

Chair: M. Mattia (*Switzerland/Italy*); CoChair: P. Barbetta (*Italy*)

Anorexia. The gap into clinical discourse

P. Barbetta (*Italy*)

How works clinical discourse in the technologic dominion? A symptom becomes a sign in diagnostic discourse if, provided technology (blood exams, endoscopy, fMri and so on), shows anomaly. But ever there's a distortion that sticks technology: There are symptoms with no signs, as in all the situations that once were called hysteria. Historically, the diagnosis can be viewed as a name applied to an illness, that becomes a disease, or a name applied to a consistent group of symptoms, that become a syndrome. Usually such a name is the one of the physician who discovered or invented such a disease or syndrome, sometimes the name of a writer (like sadism or masochism) or the name of a character in a novel (like Peter Pan syndrome).

But not ever, as we'll see later. In the case of anorexia, the change of names, was consistent with the dispositive of care concerning the disease, the syndrome, the disorder that in different periods of her (sic) history she (sic) has been.

Anorexia received its proper name in 1874 from the Lasegue's definition of anorexia hysterica. Shifting the disease from a type of hysteria - an adjective of hysteria - to a different and proper name in which hysterica became the adjective. Today anorexia is the main contemporary example of the presence into the body of symptoms with no signs. Anorexia has supplanted hysteria in this role. All the signs in anorexia are consequences of the practice of starvation and eventually the causes of some other disease, like Simmonds' syndrome. At the beginning of 20 th Century anorexia was called pituitarian disease and was for a very long time under the dominion of endocrinology. The first technological discourse on anorexia. This dominant position about starvation lasted for thirty years and more. In general, clinic technologic discourse is focused on cure: removing the cause of the disease. But there was no clear cure for Simmond's syndrome.

During the Forties Mara Selvini Palazzoli discovered that the young women she was seeing were starving, to the contrary of what Simmond was claiming, that they had no appetite. From there comes the name, given by Selvini Palazzoli: mental anorexia.

Selvini in Italy, and Hilde Bruch in the US have been the first two clinician who re-open the psychotherapeutic possibility, even thogh some cases of ED were treated in psychoanalysis, like Ellen West's one. The very practice of psychotherapy is characterized by the aim of listen to the symptoms instead of removing it technologically. In anorexia, like in the 19th – 20th Century hysteria, there are neither biologic signs, into the brain or somewhere else, nor pharmacologic treatments which work both in cure and chronicity. If we take a strong biologic position, then we must conclude with the paradox that anorexia is a mystic disease. Either we can cure it, or we embrace the mystique, a third position is uncanny. The gap into the clinical discourse concerning Anorexia faces the following ethic dilemma:

Either we take a kind of deconstructionist position towards the evidence based medicine, deconstruction that works compelling the clinician to focus on the clinical case as the benchmark of her/his activity.

Or the challenge to the technologic practices, made by anorexia triggers out the return of moral cure (Pinel, Esquirol), that re-propose the asylum. I think we have to be worried about this widespread seclusion of the anorectic women.

If hospitalization can save lives in very severe situations, the marketing phenomena we are facing is transforming such interventions in a fashionable idea of "giving the responsibility of my body to someone else".

Our positioning (as in the clinical case presented by Doctor Mattia) consists on thinking that therapy in not something dissociated to ethic and responsibility. First of all responsibility to listen to the sense and the possible meaning of the symptoms in the personal life script. The systemic position cannot be dissociated to the therapist

ethic positioning. If anorexia is still a mysterious disease, as I believe, we cannot think to put it under technologic and educational control without paying the consequences of creating an anti-ecologic "conscious purpose" (Bateson) to cure anorexia, instead of taking care of the person who became anorectic, and is going to take care of herself starting from the therapeutic process on. Any invariant in anorectic disease has an individual, familiar and cultural history in which is embedded.

Body, food, culture and development of pathologic thinness

C. Tettamanti (*Italy*)

Cultural Factors affect body image and eating habits. These also interact with biological factors determining bodyweight. How eating behaviours related to culture are correlate to the development of pathologic thinness?

There are cross-ethnic differences regarding food and body. Culture has a direct influence on quality and quantity of food ingested and the importance given to "eat": this has a strong impact on ideas about diet and weight. Between people of different ethnic groups, we can also appreciate differences in average body weight. It seems to be linked to hereditary factors, but also environmental. For example, Asians have on average a low body weight (45 kg); they feed on fish, vegetables, rice, avoiding the consumption of meat from cow, regarded as "sacred" because they work hard in the fields, giving them food. Among the Polynesians there is a high body weight (average of 130 kg). In the past they ate the "taro" and "luau" (pork), foods with high caloric contribution. After the arrival of Westerners, they became lovers of canned meat fat and high in calories.

Attitudes toward body image bring to a psychological phenomena that culturally can affect the body weight. In Western societies, in the past, women "beautiful and attractive", represented in ancient paintings, had a round face and chubby figure. At Mid 90's, the world of high fashion has strengthened the cultural imprint of the strict dietary restrictions, with the globalization of an emaciated look embodied by top-models. This model of beauty anorexic and whiskers has spread contagiously among girls who want to lose weight to look like those goddesses whose thinness is pushed by cinema, magazines, television.

To a large extent, individuals embody the culture that they live in. Artificial changes in the actual shape, size and surface of the body, which are widespread throughout the world, can also have a social function. Also the notion of "beauty" and of the optimal size and shape of the body. Thinnes, as Nasser points us, has come to symbolize "beauty, health, achievement and control".

A form of body alteration are the various forms of dieting, in order to reduce weight to more "attractive" dimensions and improve health. Why? The Western emphasis on the "ideal" slim female body can have a major impact on the incidence of eating disorders, especially anorexia and bulimia - in country undergoing economic development, urbanization and "westernisation". Exposure to images of super-slim females on television, movies, and magazines may all lead to some young women becoming glum with their body image.

Clinical approaches with eating disorders: Biomedicine and Cultural Psychiatry comparison

Biomedical approach it 'a perspective that assumes that anorexia exists as a disease that has well-documented symptoms, discovered through clinical diagnosis surveys, and that anorexia can be contracted. But there's no a specific drug to cure anorexia, unlike other syndromes (depression, schizophrenia). Anorexia understood as epidemic mental put in check any attempt to keep it under control through pharmacological intervention, that is, any attempt to hide life report by human behaviour. The responsibility for healing is not possible to delegate to pharmaceutical-therapy.

It is thought that anorexia is a natural phenomenon and as such has always existed. But consider: the holy fast of the Middle age, the hysteria of the Victorian Age, childrens of slum of Africa, who actively practice the hunger strike. We can't defined all these type of people "anorexics". I believe that an important feature of every culture

is "becoming": it is a morphogenetic capacity to change and be changed.

So, there is a need to create new open frames and methodological militancy through which "observe" anorexia?

Cultural Psychiatry can open a new horizon of sense. If the clinician sees anorexia as external data, makes it a phenomenon meaningless, or rather only considers its data quantity: the counterpart of the quantity of food needed for survival. It seems necessary and essential to take into account cultural parameters in the encounter with the suffering person, closely related to ethnic origin and to its origin, whose context allows to catch the symbolic and semantic differences. Dr. Barbetta speaks about the "cultural roots of diagnosis" (2003)

There's a need to derail by static label diagnostics of "anorexia". As long as the 'anorexic' is involved in the process of colonization of the body, learns to use medical language, constructing medical meaning being trapped. There is a risk that the diagnosis nail, delimit, close the freedom of choice of anorexics, depriving it of moral agency, responsibility. This makes anorexics (an-oregei - which stretch out your hand) blocked, jammed, closed.

Responsability has a vital importance in the processes of care therapy. For example, Milan Approach supports the acting of individuals is not determined by some force outside the disease, but people choose: the choice of anorexic is conscious and tenacious, that makes sense. In therapy, therefore, the focus shifts from talk about food (quantity, quality, frequency), to the choice.

This opens the possibility of turning the patient from a-moral agent in moral agent.

Clinical research needs a new logic of the way that reads anorexia like a cultural traces, shifting the focus beyond the "symptoms" to the "story" brought by patients. This allowed to give meaning and thickness to suffering, within a narrative existential personal, in the history of life subject and its cultural and ethnic dimension.

Anorexia as cultural traces enables departure from linearity of the rigid system of medicine and entry into a new semantic circularity, surrounding different systems and subsystems.

So, it's possible that new horizons arise; turning patients into moral agent they can become vehicles in the care of our self.

The cultural origins of anorexia through the analysis of a case study

M. Mattia (*Switzerland/Italy*)

The excessive worrie of being overweight is frequent in many societies in several parts of the world. The culture is contemporarily both inside and outside the mind. Also Gregory Bateson asserted that the mind cannot be conceived outside the historical and mainly cultural context.

Even though the causes of eating disorders are still unclear, it is thought that they may be prevailing in the societies wherein the food is reasonably plentiful.

On the other hand within the European and American societies there is a tendency to emphasising thinness as a sign of beauty and healthiness.

On the basis of these socio-cultural factors anorexia is considered as a specific syndrome which is correlated to the Western culture and mainly found within the European and American society.

Also within the psychological literature concerning anthropology anorexia nervosa is included in the culture-bound syndromes.

It has been shown that the persons coming from ethnic and cultural groups wherein there traditionally is a low prevalence of eating disorders emigrating to countries where there is a high rate of eating disorders are more vulnerable to develop these pathologic patterns.

According to Katzman and Lee in the transition societies of the more agricultural and rural civilisations to the more industrial and therefore western ones, the youngsters could develop eating disorders of anorexic type not only as an imitation of the socio-cultural ideals of the western beauty, but also as a reaction to a situation of high inter-family emotionality which is typical of the transitional families between the patriarchal model to the modern one. According to several Authors transcultural migrations causes changes in the family value-system and life-style, which, somehow, make immigrated adolescents

particularly susceptible to eating disorders. Anna's anorexia sprouted during adolescence (she was 15 years old), a time when parents start specifying their wishes, needs, orientations and expectations more clearly. The infra-generational conflict is particularly strong in the relationship with daughters, as parents seem to be more demanding with them. As soon as it was possible to go to another level of therapy, we managed to enter the cultural framework of meanings which allowed to access the distorted family myths revolving around the constant desire to return to the home country. Anna suffered from a restrictive anorexia with a strong reduction of the food-intake and fasting periods, as well as continuous physical exercise. In fact one of Anna's characteristics was anguish and obsessive anxiety towards food and in particular the presence of a strong body dysmorphic disorder (BDD) related to food intake. To Anna though, the origin of her anorexia was tied to her obsessive thoughts, to her depressed state of mind and, particularly, to the ever present family prospect that one day they would magically return to their home country. One of the cultural characteristics of the family's structure was to channel all affective and love-related communications through food. Anorexia took the form of a sovereign freedom within a family system that held her captive, a family that inhibited and regressed the evolution of the integrating Ego and therefore free from cultural expectations of a migrant family. The family was hence undergoing an internal crisis and Anna, as a second generation migrant, represented the potentials and also the risks brought about by the migration process. The anorexic behaviour therefore served as a means to keep the family united and to allow each member to tolerate the distance from their home country, the heimweh and above all to continue living this migration as just a period of life that is suspended. Resolving this conflict finally allowed Anna to get out of the clash between the two cultures. She was finally able to undertake her own journey to maturity and differentiation while also distancing herself from the trap of anorexia which so far had only halted her cultural, social and emotive evolution.

The presented case study triggered various reflections among the therapists, among which one can count:

1. The importance of recognising the most subtle psychopathologic symptoms and the differences among them.
2. The importance of a close co-operation between the therapist, the psychiatrist and the nutritionist, which in this specific case allowed us to exit the therapeutic triangulation.
3. The priority given within the family system and the therapeutic team so as to prevent the risk of disconfirmation and of refusal.
4. The rule not to discuss food, unless a previously defined BMI was reached. If the subject always remained above this BMI level the argument "food" was not discussed. This allowed the patient to come to the therapeutic sessions without the anguish of being questioned about what she has eaten.
5. The sense of responsibility.

Round Table (RT-1)

Diagnosis in cultural psychiatry. Current databases in the DSM-V Process

Chair: R. Alarcón (*USA*) ; CoChair: F. Lu (*USA*)

The historical evolution of diagnosis in both medicine and psychiatry has moved the concept from a traditional systematization of knowledge, delineation of clinical symptoms and syndromes, superficial implications of causality and course, and generic guidelines for treatments and assessment of outcomes, to the modern view provided by basic epidemiology, elucidation of risk and protective factors, roles of families and communities and, most importantly, the incorporation of cultural elements. Essential cultural variables, key cultural concepts, and solid ethnographic data are relevant tools in this process, beyond the gene-environment equation. A research agenda focused on methodology, cultural epidemiology, service and outcomes research, and special topics (violence, trauma, gender, stigmatization, racism, and acculturation) has been developed. Current debates about DSM-V, for instance, focus on a multidimensional vs. categorical approach, mono axial or multiaxial structures, idiographic formulations, risk factors assessment, whole diagnostic reframing), and multidisciplinary convergences, particularly with social sciences and primary care and other medical specialties.

This presentation examines a variety of cultural factors impacting on psychiatric diagnosis, and key concepts in culturally relevant diagnosis-oriented clinical research. A program of this nature should include conceptual, operational and topical issues. The conceptual area deals with the elucidation of evidence- and value-based approaches, the gene-environment interactions, and the cross-cultural applicability of diagnosis. Operational issues cover the connections between culture and perception of symptoms, dimensional vs. categorical approaches, use of instruments, and generation of research teams. Research priorities should not rely only on conventional epidemiological approaches, and a cultural axis should be ruled out. Topical issues entail ethnicity and identity, bio-cultural links in psychopathology, a niche for "culture-bound syndromes," stigma and racism, and barriers to care and diagnosis, among others.

The cultural content of DSM-V or any psychiatric classification should include as well an improved cultural formulation, culturally-based risk and protective factors, culture's interpretive/explanatory functions, and the application of pharmacogenomics in different ethnic groups. Pathogenic and pathoplastic considerations should also emphasize the role of culture. Cultural explanations must address vulnerability and resilience, characterological instability, maladaptive potential, help-seeking patterns, and chronicity-feeding factors. Cultural identity must be a part of the diagnostic assessment. Finally, it is important to assess research trends in order to measure the acceptance and pertinence of interactions between culture and diagnosis.

Round Table (RT-2)

Working with racial cultural issues within ourselves with our colleagues and with our patients

Chair: M. Ascoli (*UK/Italy*); Cochair: K. Bhui (*UK*)

During this symposium, the Chair and the Co-Chair, after a brief introduction and presentation, will encourage the participants to draw from their clinical practices and share examples of how, still nowadays, racism, slavery and colonialism carry a traumatic psychological legacy which continues to influence the relationships among people of different races and cultures within society at large.

The debate, however, is particularly difficult to have, as racial identity lies deeply in the realm of the intra-psychic, and openly facing racial issues tends to trigger emotions which are deep, often unexplored and difficult to manage. Therefore the racial debate moves in between the poles of the politically correct (useless) and the heated conflict (hurtful).

The purpose of the workshop is to reflect on racial dynamics in interpersonal and therapeutic relationships, to show how they can act destructively within the psyche of the individual, and to reflect on how it is possible to work on these dynamics at a personal level and with our colleagues and patients.

FOURTH DAY - September 30 (Wednesday)

Plenary Session (P-8)
Neuroscience and Culture (In honour of Nicola Lalli)

Chair: V. De Luca (*Italy*); CoChair: J. Y. Chiao (*USA*)

Introduction

L. Stuppia (*Italy*)

The existence of individual differences in intelligence is a prominent aspect of human psychology, and it is well known that they can influence important life outcomes. The origin of individual differences in intelligence has been largely debated, and one of the biggest question is whether it is due to genetics or environment, commonly referred as the "nature vs nurture" debate. A large series of data collected in the last years have demonstrated that variability in cognitive abilities among different individuals are due to the interaction of genetic and environmental factors: genetics account for about 50% of difference among individual, while shared and non-shared environment account for 25% and 20%, respectively, the latter 5% being represented by errors in the evaluation of the cognitive abilities. Data on animal models have demonstrated that environment is able to modify genetically determined cognitive abilities, and that enriched environment can improve the performance of obtuse rats, even in presence of genetic abnormalities.

However, the role played by genetics and environment does not remain the same during the entire lifetime. In fact, It has been demonstrated that the genetic component of human intelligence increase with age. This is due by the genetically determined mechanism of neuronal repair, whose role becomes crucial with aging, but also by the reduction of the shared environment. The most recent models of gene-environment interaction in the determination of human intelligence postulate that at each age specific genetic and environmental influences occurs, producing a variability of IQ even within the same individual. Further evidence for the gene-environment interaction comes from the study of the psychiatric diseases, and in particular by the specific endophenotypes. These are biological markers of diseases such schizophrenia or mood disorders, which are genetically determined and are transmitted in a mendelian manner. These endophenotypes do not directly induce the disease, but represent the individual susceptibility to the disease. Theese susceptibility will produce a disease only in presence of environmental factor. Taken together, all these data demonstrate that the "nature vs nurture" debate is no more useful. Nature and nurture works together in the determination of human intelligence, and among environmental factor a crucial role in human is played by culture.

Cultural Neuroscience. Implication of Biocultural Diversity for Cultural Psychiatry

J. Y. Chiao (*USA*)

The past century has witnessed a number of theoretical attempts within psychology to integrate cultural and neurobiological approaches in the study of the human mind and behavior. Cultural neuroscience is an emerging research discipline that investigates cultural variation in psychological, neural and genomic processes as a means of articulating the bidirectional relationship of these processes and their emergent properties.

In this talk, I will present the principle aims and methods of cultural neuroscience, drawing from recent empirical evidence for how cultural values, beliefs and practices shape neural

mechanisms underlying typical and atypical social and emotional behavior. Implications of cultural neuroscience for public policy, interethnic ideology and cultural psychiatry will be discussed.

Transcultural Neuroimaging

T. Stompe (*Austria*)

The aim of this presentation is to outline the importance of the relatively novel approach of transcultural neuroimaging in bridging the gap between neuroscientific investigation of supposedly culture-invariant neural mechanisms and the psychological exploration of culture-sensitive cognitions. Recent findings have demonstrated that cultural differences modulate neural activity at multiple-level functions. This raises several conceptual issues concerning the distinctions between modulatory versus constitutional cultural impact and the relationship between nature versus nurture. Additionally a current joint research project is introduced, which aims to investigate the cognitive and neural mechanisms underlying the modulation of empathy by human social relations and cultural backgrounds. An important issue that has been addressed by recent social cognitive neuroscience studies is how the human brain understands and shares the feeling of other individuals. Our research project aims to investigate the cognitive and neural mechanisms underlying the modulation of empathy by human social relations and cultural backgrounds. Neural activity in association with empathy will be recorded from different cultural groups using brain imaging techniques such as functional MRI and event related brain potentials. We want to examine how the cognitive and emotional components of empathy are modulated social ingroup/outgroup relationship and whether such modulation of empathy depend on participants' cultural backgrounds and attitudes toward ingroup/outgroup members. The findings of our proposed study shall help to understand the neurocognitive basis of human empathy and the functional role of empathy in social conflicts between different social groups.

A Biocultural framework for spirituality

V. De Luca (*Italy*), N. Lalli, G.G. Rovera (*Italy*), M. Ascoli (*Italy*), A. Eligi (*Italy*), V. Infante (*Italy*), G. Bartocci (*Italy*)

The study of religious experiences and spiritual life has always been a classical topic of cultural psychiatry. Different models have been suggested for the subjective and collective meaning of mystical/religious experiences, their impact on mental life and their adaptive vs. pathological value in clinical terms.

Anthropological studies have contributed mainly to the former, while transcultural clinical psychiatry has explored the latters, but neuroscience contribution seems to have shifted the attention on neural correlates of subjective experiences, including religious ones. While addressing the quality of religious experiences, neuroscience and cultural psychiatry cannot help facing the problem of their intertwining with the dilemma of consciousness, the debate on its definition (or even of its existence) and the models of its normal and altered states.

The increasing interest in cultural factors contributing to the mental processes and in the role of culture in brain activity, representation and experiences (i.e., the modern cultural neuroscience) is likely to help in constructing an integrated model for the understanding of the spiritual experience.

Standard Symposium (SS-VI-26)

Mental Health of Population of Siberia. Transcultural Aspects

Chair: V. Semke (*Russia*); Cochair: I. Kupriyanova (*Russia*)

Strategy of transcultural approaches in Siberia

V. Semke (*Russia*)

From positions of building of a new discipline of ethnopsychology and ethnopsychotherapy (as well as its branch "clinical personology") it is extraordinarily important to outline the circle of primary and relevant problems, subsequent structure, including the "roof" of this scientific branch (Pfeiffer, 1994). The matter is about influence of social-political and social-economic changes in societal life of some countries and peoples as well as in life of living on these territories citizens; about the role of variable national, cultural, religious traditions in emergence and dynamic of neuro-mental (including personality one) pathology; about attitude of various ethnoses toward difficult questions of mental health and its possible deviations (in the first place, neurotic and pathocharacterological ones); finely, about establishment of association of ethnocultural factors with prevalence, clinical structure, dynamic and prognosis of mental disorders.

As a theoretic base of teaching about mental shifts in representatives of some ethnoses we indicate principles of creative synthesis of traditionally interacting cultures and areas, idea of dynamic of cultural systems and multi-linearity of the development, further perfection of concept of cultural-ecological adaptation. The practical object for ethnopsychologists is research of influence of geographic, cultural and societal conditions where the people lives, normal and ill notions, background and incidence rate of psychopathological symptoms and states, choice of preventive forms of providing mental health of separate individuals and the people as a whole.

Ethnopsychology studies evidence, regularities and mechanisms of manifestation of mental typology, valuable orientations and behavior of representatives of this or that ethnic community living for centuries in one and the same geohistoric space. Cross-cultural investigations put stress on comparison of mental symptoms and diseases in peoples and ethnoses with account for their sociocultural patterns and ethnographic data. Transcultural study limits itself as a role by comparative rating of mental disorders, choice of treatment methods, organizing forms, psychological (or psychiatric) providing and other aspects of mental life of peoples on various continents. Fully essentially that all depends on integrity of studied ethnos – at what stage of the ontogenesis examined people, populations are, what is the dynamic of social development, their safety in historical aspect (in a known meaning, maintenance of "relationship of times"). Traditional ethnopsychological investigations represent division of psychological anthropology – discipline formed in interaction of psychology and anthropology.

Transcultural personology and psychotherapy represent humanistic trend in spectrum of the contemporary natural sciences with integrative understanding in the course of coming-to-be of the personality of role of psychological bases of culture, religion, mythology, traditions and customs. Having polyvalent relationships with medicine and sociology, ethnopsychology and personology allow from multidisciplinary positions rating the contribution of social and biological factors into genesis, dynamic, prognosis and prevention of pathocharacterological deviations in the scale "normal – pathological personality" both at societal and individual level.

Quality of life and psychological health of representatives of scanty peoples of Russia (first of all, circumpolar populations) has been importantly influenced by experienced by them throughout many decades acculturation stress that is considered as a population variant of posttraumatic stress disorder. For overcoming the negative influences of scientific-technical progress there is a need for complex social-psychological technologies of rehabilitation of arctic population, maintenance and restoration of lost by ethnoses customs and traditions.

During many centuries districts of Northern Asia (Circumpolar region), Chukotka, Kamchatka, Greenland and Alaska (20-11 thousands years ago) were inhabited by hunters for elk in the forest, for reindeer and mammoth in tundra, sea animal through coast of northern seas.

Excitement has been provoked and is provoked up to present time by perfection of mechanisms of adaptation to rigorous environment of living of these aborigines (native inhabitants, from olden times living on these territories), their ability to maintain long-term balance in interrelations with rigorous but close to them in spirit natural environment. This established experience, personality stereotype and life style were with cruelty "deformed" since the middle of the XXth century on the side of European population. This means violation of traditional ways of household, thoughtless extermination of the environment having provided conditions of support of the aboriginal ethnos. In brought to the northerner civilization there was not a worthy place for specific ethnoses. Let us think of who represented the culture of a "white man" on hidden snowy spaces of North Asia. These were first of all representatives of official-bureaucratic apparatus that is all-national and the same in all countries, in all times. Turned out for an aboriginal inhabitant of North tragedy of expansion of Europeans into the Arctic was a new act in ethnoecological history of many peoples which most dramatic moment were illnesses (tuberculosis, measles, waterpox), sufficiently favorably experienced by newcomers but causing high lethality in aborigines without immunity. This picture is added with imposed by migrants (according to mechanism of "kindling") pathological craving of arctic Mongoloids for alcohol (Galaktionov et al., 1994).

Unfortunately, long-term "closeness of the topic", peculiar "family secret of the state" did not allow developing many interesting positions and obtained earlier results of expeditionary investigations. In particular it is necessary to make up for lost moments, multiply accumulated scientific wealth, and attach to complex many-year developments the preventive "impetus", aimed at restoration of mental health and well-being. Politics of leveling and removal of available "faults" in the field of individual and societal health care should be built in aspect of forecasting of social-economic reformations, strengthening and revival of sociocultural peculiarities of a specific ethnos, overcoming the threat of "syndrome of burnout of the population and ethnos" (Kaznacheyev V. P.), efficacious transition from empty rhetoric to effective measures on restoration of human rights of a personality and thereafter also a separate people as a whole.

One of actual problems of transcultural personology is elucidation of interrelations of psychology of an individual and public culture. The latter is considered as a double, shadow, mirror of psychic (Nathan, 1987). According to theory of language a symptom is considered as coded, embodied in a word cultural-societal and individual-biological content (meaning) with account of which subjective personality assessment is built. Our many-tear experience of complex epidemiologic, clinical and neurophysiologic assessment of mental health of scanty nationalities of the eastern region of country (North of Tyumen and Tomsk Districts, Yakutia, Tuva, Buryatiya, Chukotka, Primorye) as compared with analogous indices of our Mongolian colleagues (headed by Professor L. Erdenebayar and Dorzhazhadamba), obtained in the course of realization of a complex joint scientific program testifies to unconditional priority of complex psychosocial conflicts above natural-environmental ones (Semke V. Ya., 1994, 1995, 1999, 2000).

In the epoch of scientific-technical revolution (creation of territorial-industrial complexes, urbanization, abrupt changing of life environment, transition to settled lifestyle) the specific weight of psychotraumatic experiences and conflicts with high personality social-cultural selectivity and often acquiring macrosocial character, i.e. exerting influence not on a separate individual but on the population as a whole considerably increases. The matter is first of all painful breakage of formed during centuries life (including production) style, sociocultural traditions, loss of previous trades and acquisition of professions not corresponding to typological properties of aborigines, isolation since childhood from familial home etc. Hence often psychodisadaptive states occur resulting quite often in long-term, persistent borderline and addictive personality disorders. In this association moral-ethical aspect of the contemporary transculturology is manifested acutely: How much justified is expansion of STR into the culture of an ethnos? What are limits and volumes of supposed sociocultural reforms?

In vast Siberian territories of countries in place of living of aboriginal and scanty peoples (Altaians, Selkups, Khants, Mansi, Nganasans, Dolgans, Chukchi, Evens, Evenks, Shorts etc.) currently extremely averse medico-demographic situation with increasing negative consequences caused by social-psychological, ecological factors has been formed. Occurring complex psychobiosocial conflicts should, in our opinion, be overcome both by evolutionary and revolutionary way (including return to most significant for this ethnos elements of patriarchal

lifestyle and traditional trades). Powerful man-made pressing on biological structures of the personality initiates a special acuteness of ecological impacts adversely affecting health of ethnoses. This is testified by indices of immune imbalance in population living in technogenically polluted areas. In addition to purely medical activities an urgent changing of adverse social-economic and psychological characteristics directed at perfection of physical and spiritual evolution of scanty ethnoses is needed.

Population-epidemiologic analysis testifies to increasing prevalence among aboriginal population of eastern region of borderline personality and addictive disorders. Their clinical picture differs by considerable peculiarity having its roots in ethnogenesis and culturogenesis of this people. Traditional criteria of diagnosis and identification of mental health level of studied ethnoses are of relative value and should be revised with account for clinical-dynamic parameters, necessary knowledge of cultural, social, demographic, ethnic and regional characteristics. First of all, difficulties concern separate symptoms and states ("nervousness", "irritability", "explosiveness", and "obtrusiveness"), their correlation with mental norm and pathology. The mentioned determines relevance of revision of borders of norm of mental response that is not only deeply individual but also transcultural one. Notion of normative behavior not always corresponding to European standards needs psychological and clinical revision: that is regarded by us as mental disorder; from positions of aborigines is not always pathology. Concerned problem about facets between norm and pathology is naturally not new.

Of interest is recent attempt to find points of an analysis in assessment of activity of human psyche – pole of norm and pathology. This position facilitates qualification under conditions of psychotherapeutic work with the patient of corresponding to natural meanings clinical syndrome. These are some variants of their possible distribution: anxious syndrome at one pole is represented by reaction, neurosis, at the other – self-preservation instinct. Hysterical syndrome has at one pole registered clinical manifestations of neurosis, at the other – hysteric normative mechanisms of response allowing flexibly adapt to environment. In depressive syndrome clinical manifestations of depression are opposed by psychological phenomena of sadness (associated with loss or failed wanted). To asthenic clinical syndrome of nervous weakness at normative pole sensation of overloading, lack of time, forces and emotional interest corresponds etc.

In hypochondriac syndrome to experience of unpleasant sensations on the side of organs and systems at normative level control of activity of the organism (as a self-modulated mechanism) corresponds etc.

The mentioned visibly illustrates conclusion that in state of the "norm" there are analogs of clinical syndromes playing essential role in emotional-volitional and intellectual life of the personality.

Contemporary transculturology dictates revision of rendering the psychological and psychotherapeutic assistance for aboriginal population of circumpolar region – first of all in direction at dialectical combination of principles of centralization and decentralization (with account for low density of living). Theoretic significance and practical value of distinguishing "risk groups" and so called pre-nosological states as well as prognostic criteria of progression of borderline and addictive personality disorders are distinctively outlined. During development of preventive activities the entire complex of medico-social sociocultural interventions should be taken into account that should be flexible and not violate human rights. This concerns especially peoples of North Asia with account for their ethnocultural traditions. Development of transcultural aspects of personology bears in itself not only important theoretic incentive associated first of all with crystallization of biosocial paradigm but also powerful sociotherapeutic, preventive impetus.

Transcultural and cross-cultural psychology, personology and psychotherapy based on integrity of sciences and modern technologies should immediately resolve global negative problems of convergence (Germany) and divergence (Russia, countries of CIS etc.) of entire states and peoples (Semke, 2000). As a consequence of psychological distress impetuous increase of borderline personality disorders, addictive and suicidal behavior is observed. During existing instable conceptuality and similarity of crisis problems in different countries (first of all from number of closely collaborating with the International Association of Ethnopsychologists and Ethnopsychotherapists), specific for every of them tasks of objectification of psychological and psychopathologic phenomena of transcultural spectrum should be solved. The basic strategy of the Association is development of new preventive programs for rehabilitation of the population

under crisis conditions with observance of ethnic norms of personology and psychiatry. Main principles of its work: to take for account interests of ethnoses and nationalities (without violation of ethnoecological basis), to take care of protection of life, health, facilitation of suffering of a patient. Association is called in new millennium to resolve successfully new problems: striving for earthy aims to overcome awful consequences of national hostility, to promote destruction of discrimination positions both between countries and internal ones. The forthcoming generations have to go forth along a human way uniting various races and peoples into a common humanistic community.

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Clinical-ethnocultural peculiarities of alchoholism among aboriginal population of Kamchatka

N. Bokhan (*Russia*)

Beginning in the XIXth and reaching its maximum in the XXth century process of acculturation of minorities of Far East, characterized by destabilizing influence of newcomers, adoption of alien traditions, in particular, tradition of alcohol consumption ideologically conditioned by attempts to cultivate in aborigines not inherent in them norms and values resulted in destruction of historically formed life stereotype of these ethnoses, loss by them of their cultural-ecological roots — native language, ritual and festal customs, national moral. (Semke, Bokhan, 2008) All this has undermines balanced bases of existence of archaic populations and has contributed to formation in many of them of various forms of mental disadaptation and destructive behavior, one of which is alcoholism (Semke, Erdenebayar, Bokhan, Semke AV, 2001). Such a swift, from evolutional viewpoint, introduction of alcohol into daily life of aborigines has caused in them serious biological (neuroendocrine, enzymatic) dysfunctions that in total with traditionally low content of alcoholdehydrogenase in the organism create biological preconditions of severe course of alcoholism in representatives of minorities of Far East.

Definition "indigenous peoples" ("aboriginal ethnic minorities", "tribal groups", "tribes included into lists") has been given in Operational Directive (OD) 4.20 of the World Bank "Indigenous peoples". In clause 3, definition of indigenous peoples has been given as social groups with societal and cultural identity different from predominant majority what makes them vulnerable from the viewpoint of adverse conditions for development.

In our work we are guided by presented here in clause 5 characteristics (signs) of aboriginal peoples: close relationship with tribal fields and natural resources; awareness of their belonging to a peculiar cultural community; presence of language of aboriginal inhabitants, presence of traditional and political institutes, predominantly natural economy.

Kamchatskaya District and Koryaksky Autonomous Okrug represent a natural training ground for comparative study of ethnocultural aspects of alcoholism in Slavonic and aboriginal peoples. This is conditioned by that in the region, great number of Far East scanty people lives (Koryaks, Evens, Aleuts, Chukchi, Itelmens, Yakuts, and Nivkhi etc.).

The highest level of morbidity has been documented among Koryaks (27,6-30,5 per 1000) and Evens (27,4-28,4). Among Aleuts and Itelmens it appeared to be lower within 16 per 1000 of representatives of this ethnos In all ethnic groups of aborigines morbidity with alcoholism among men reliably exceeded that among women (differences of indices reached from 1,9 to 6 times), what indicates major liability to this disease of men. The highest level of prevalence of alcoholism has been revealed in Evens-men (49.1-53.0 per 1000).

Comparative study of social and ethnocultural characteristics of suffering from alcoholism persons of aboriginal and Slavonic nationalities has allowed revealing the following peculiarities: only 25% of aborigines regard as native one language of their nationality what testifies to loss by most of them of their cultural-ecological roots. This results in loss of personal integrity and weakens psychological stability facilitating development of alcohol dependence.

It has been established that overwhelming majority (more than 80%) of patients of both nationalities have grown under conditions of pathologic up-bringing. Thereby its most prevalent variant, both in aborigines and Slavs was authoritative, promoting formation of such traits of the personality as passivity, lack of volition, inability to resist difficulties. Such personal predisposition creates the most appropriate conditions for development of alcohol dependence.

In both ethnic groups of patients persons with primary and secondary school education predominated.

Concerning professional employment of patients, so both groups of patients differed by great number of unemployed. Thereby among Slavs such ones constituted two thirds, among aborigines - about a half. This testifies to not only disadaptation of alcoholic patients but also reflects adverse social-economic situation in Krai, especially in its rural districts.

About a half of patients of both ethnic groups has not a family that indicates their severe disadaptation in family-everyday domain. Additionally, in patients who had their own families, relations in them in two third of cases bear destructive or formal character. This regularity to equal extent is typical both for Slavs and aborigines.

In patients of native nationalities leading place in system of personality values is occupied by material well being, and in Slavs – marriage and family. In studied groups of patients as church people about a half of Slavs regarded themselves and among aborigines – more than one forth of aborigines. Thereby in 67,2% of aborigines typical peculiarity was belief in traditional heathen in their essence cults. More than one third of church people-patients of both nationalities differed by such a form of expression of religious beliefs as "belief in soul", i.e. belief without observance of established religious exercises. In addition, 60% of believing Slavs address religion only in critical situations what is more adequate in its essence for psychological defense according to type of superstition. Summarizing, it may be said that patients of both ethnic groups are to major extent superstitious but not believing in true meaning of this word. This is why, therapeutic and rehabilitative activities should be conducted with account for mentioned peculiarities.

As a result of conducted investigation we succeed to identify both similarities and differences according to basic clinical parameters of alcohol dependence in patients of compared ethnic groups. First of all, we shall touch upon differences that should be taken into account in preventive and treatment-rehabilitation work with patients.

So, in 39,4% of patients of both nationalities we have revealed adverse premorbid features of the personality. Thereby for aborigines most typical ones were protest and aggressive forms of behavior and for Slavs – complexes of their own low self-esteem.

Formation of alcoholism in studied patients was promoted by incorrect attitude of parents toward alcohol consumption by their children. So, about half of mothers and two thirds of fathers of future patients have an indifferent attitude toward this or even themselves trained their children to consume alcohol. This adverse phenomenon is more prevalent in families of aboriginal peoples. Thereby in Russians indifference was relatively more often revealed and in aborigines – in fact, welding of children.

For alcoholic patients of both ethnic groups early onset of systematic alcohol consumption is typical, to special extent it concerns aborigines.

Among them portion of persons with onset of systematic alcoholization at the age of 15—17 years, exceeds analogous index among Slavs 4 times and at the age of 18—25 years — 2,4 times. In its turn, among patients of Slavonic nationalities specific weight of persons with onset of systematic alcohol consumption at the age of 31-40 years is higher 3,8 times. Especially

indicative that among alcoholic patients-Slavs number of persons with onset of systematic alcohol consumption after 40 years constitutes 26,7%, so among patients-aborigines there were not such at all.

Study of patients of aboriginal nationalities has shown that in them the most prevalent motivations of alcohol consumption are traditional meaning entering the tradition alcoholization, — 92,3% of all patients; deprivation-affective (loneliness, anguish, sensation of abandonment) — 79,8% and hyperactivation (for heightening of power of endurance) — 75%. The second in incidence group of motivations has been constituted by: pseudo-cultural (ritualization of alcohol consumption) — 69,7%, submissive (subordination to requirements of the microsocial groups) — 64,9% and macrosocial (determined by worsening the social-economic situation in country, unemployment, decrease of life level, social insecurity — 63%. The third group has been entered by two forms of motivations: hedonistic (obtaining the pleasure, euphoria) — 49% and asthenic (inability to overcome life difficulties) — 39,9%. Less prevalent motives have been included into the forth group. These are as follows: ataractic (calming, removal of mental tension) — 20,2% of patients, family-household (absence of well-being in family life accompanying by conflicts, scandals, divorce) — the same 20,2%, auto-destructive (protest behavior) — 18,8% and ambition (strive for self-assertion, non-satisfaction with his/her position in the society) — 13%. In patients of Slavonic nationalities the leading position is occupied by alcoholic traditions of the society — 80,7% of all patients. Portions of the rest factors constitute from 40% to 66% of cases.

Among patients-aborigines as compared with Slavs specific weight of submissive, pseudo-cultural and hyperactivation motivations is reliably higher, and in Slavs — hedonistic, ataractic, family-household, ambition and asthenic ones. This data reflect more inherent in Slavs reflection and uncertainty in him/herself, strive artificially, without their own efforts to change his/her mental state (either toward euphoria or toward calming), finely, high need for feeling of his/her significance accompanying by overrated self-esteem and hypertrophic ambitions. In addition, among Slavs portion of patients in whom motives of alcohol abuse are associated with family problems exceeds that in aborigines 3,3 times. In our opinion this indicates not the greater family well-being in aboriginal peoples but comparably less significance for them of family-household problems.

Identification of primary kind of alcohol consumption has shown that almost half of all suffering from alcoholism aborigines (47,6%) consume mainly spirits (vodka, spirit). The fifth part of all patients (22,1%) consumes in succession without preference of any kind of alcohol. Other kinds of alcohol are consumed by aborigines reliably more seldom. Patients of Slavonic nationalities also in their majority consume spirits — 44%; drink "in succession" — 14,6%.

Relatively low middle daily dose of alcohol consumption (0,5 l) is found in patients-aborigines two times as frequent that in patients-Slavs (84,1 and 42%, respectively). In its turn, among the latter specific weight of persons with high daily dose is higher (from 0,5 to 1,5 l and more) — 58% vs. 15,9% among aborigines; difference 3,6 times. Obtained data testify to significantly lower tolerance to alcohol in suffering from alcoholism aborigines.

Among patients-Slavs, as compared with aborigines, portion of alcohol consumers against the background of high tolerance 3-4 times in a week or daily is higher. In its turn, in group of patients of aboriginal nationalities specific weight of persons, daily consuming alcohol against the background of low tolerance as well as patients with drinking bouts emerging several times a month is higher. Revealed differences confirm conclusion about lower tolerance in suffering from alcoholism aborigines as well as indicate severity of clinical manifestations of the illness in this ethnic group of the population.

Study of clinical variants of character of intoxication in compared ethnic groups of patients has shown that almost in a half of patients of aboriginal nationalities intoxication with explosiveness, psychomotor arousal and aggression that during continued intake of alcohol (rausch-alcoholization) proceed to torpor accompanying by occurrence of sluggishness, drowsiness, dormancy is noticed, other variants of intoxication are revealed reliably more seldom. In patients-Slavs of predominance is simple intoxication (3-2,7% of all cases), while various forms of changed intoxication are found reliably more seldom: intoxication with explosiveness (16,7%), with depression (14%), with hysteric manifestations (12%).

Comparative study of clinical variants of abstinent syndrome in studied groups of patients has allowed identifying that in persons of aboriginal nationalities of most frequent revealing

is withdrawal syndrome with mental disorders — 53,9% of all cases. The second most prevalent is withdrawal syndrome with vegetative-somatic disorders — 34,9%. In patients-Slavs, vice versa, withdrawal syndrome with vegetative-somatic disorders dominates — 46%, and withdrawal syndrome with mental disorders is found more seldom — 34% of cases.

During consideration of predominant form of alcohol consumption by patients of compared ethnic groups it was identified that in suffering from alcohol dependence aborigines the leading form of alcohol consumption is pseudo-dipsomania (49% of cases), lasting most frequently 5—7 days. The rest are as follows: constant drinking against the background of low tolerance — 23,6%, constant alcohol consumption against the background of high tolerance — 16,8%, Conducted comparative analysis of ethnocultural peculiarities of alcoholism in aboriginal and Slavonic peoples of Kamchatskaya District and inhabitants of Koryaksky Autonomous Okrug has allowed stating that for aborigines higher prevalence of alcoholism, greater severity of its clinical manifestations, adverse course, sever progression, higher incidence rate and degree of alcoholic changes of the personality, moral-ethnic and intellectual-mnestic loss, social and professional degradation are typical.

In patients of both ethnic groups the leading place among motivations of alcohol consumption is occupied by existing in the society alcohol traditions. Also, in aborigines their influence is expressed somewhat more considerable in spite of that originally in culture of aboriginal peoples of Far East such traditions were absent at all. In both ethnic groups deprivation-affective, auto-destructive and macrosocial motivations are practically equal in incidence rate.

Positive influence on resolution of the problem of overcoming the phenomenon of acculturation of the aboriginal population has been exerted by international regulatory enactment acts and in particular Convention of ILO "About aboriginal peoples and peoples carrying on tribal life style in independent countries", that was accepted by General Conference of the International Labor Organization (ILO) June 26, 1989. It envisages inclusively the following positions:

- responsibility on the side of governments for carrying out, with participation of corresponding peoples, concordant and systematic activity on protection of rights of aboriginal peoples;
- recognition and care for social, cultural, religious and spiritual values of peoples, respect of their violability;
- carrying out consulting of governments with these peoples through their representative institutions during consideration of legislative and administrative issues affecting interests of aboriginal people;
- right for aboriginal people to resolve issues of choice of priority of their development (cultural, economic, spiritual);
- maintenance by aboriginal people of their customs and institutions;
- recognition for aboriginal people of rights of property and ownership of lands those are occupied by them traditionally.

Currently, Russian Federation does not bear direct juridical commitment to introduce norms of convention into law system. In addition, membership of Russia in ILO conditions necessity to take into account conventional positions in the internal policy.

As a conclusion we should stress that process of depopulation in archaic ethnoses of Siberia – this is the influence of complex aggregate of factors, first of all alcoholism, phenomenon of acculturation as well as urbanization and other industrial impacts in proved vulnerability of scanty ethnoses to broad spectrum of mental disorders. Together, it indicates high probability of adverse scenario of development of addictive pathology among aboriginal population of Siberia. Recognition of this requires further scaled activities on prevention based on scientific analysis of the problem and interdisciplinary responsibility for problem resolution.

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Factors influencing on mental health state of schoolchildren in Buryat rural population

B. Dashiyeva (*Russia*), I. Kupriyanova (*Russia*)

We have carried out investigation of borderline neuro-mental disorders in Buryats, schoolchildren of a rural school (village Utata, Republic of Buryatiya) for 1999-2003. As an object of investigation choice of village Utata of Zakamensky district of Republic Buryatiya is explained by the following moments: homogeneity of population, geographic isolation. These factors promoted lesser influence of acculturation processes, maintenance of the language, traditional culture, customs, style of life and forms of economy.

Population as a whole consists of persons of Buryat nationality, according to data of expedition of 1999 constitutes 684 persons - 332 men and 352 women (48,5% and 51,5%, respectively).

Basic occupation of the population is animal breeding, to lesser extant - hunting. Women predominantly are occupied with keeping household and upbringing the children. Small part of them is engaged in educational process, in the sphere of serving of available institutions and also as primary and secondary health care unit of first-aid and obstetric station.

School contingent consisted of 147 persons - 69 boys, 78 girls. The analysis has been entered by 144 schoolchildren (98% of schoolchildren of the secondary school).

Group of able-bodied age consists of 197 men (28,8%) and 161 women (23,5%). Children and persons of declining years constitute 135 persons of male sex (40,62%), from them 107 children – 32,2% and 28 persons – 8,4% of pensioners; and 191 persons of female sex (59,4%), out of them 116 children – 33,0% and 75 persons of senior age group – 21,3%.

Sex-age characteristics of parents of schoolchildren has shown that major part of parents is at the age of 31-40 years (41,1%). Portion of parents at the age of 41-50 years (36,6%) is somewhat lesser. Age groups up to 30 years and older that 50 years are represented equally (11,7% and 10,6%).

Structure of families depending on number of children is represented as follows: in equal values – families with two, three children and families having many children (28,1%, 31,2%, 31,9%, respectively), lesser than 9% falls on the portion of families with one child. Maximum number of children in the family is 9-12, in average, families having many children have 6-8 children.

Such a position is a reflection of value orientations of Buryat people where family having many children, children, alliances is of prior value. However, it is worth to say that for last 10-15 years negative demographic trend is noticed that is manifested in reduction of number of children (both wanted and actual), increase of number of abortions, decrease of life expectancy, increase of mortality from such causes as an accident, poisoning with alcohol surrogates, suicides etc.

Average number of children in families - 3,45 (average value according to results of two expeditions). Analysis of this index in dynamics testifies to its constant decrease. So, in 1999 average number of children was 3,8, and in 2003 – 3,1.

Wanted number of children in young families approximates to actual and does not exceed the index "2-3 children". Such changes may be considered also as consequences of adverse social-economic conditions and as result of influence of culture of dominating in republic ethnos (Russian), for which few children are typical. These changes are a reflection of negative demographic processes occurring as a whole in republic that can bring significant losses in future for Buryat people. Because major part of the aboriginal population of Buryatiya lives in rural area namely with it possibility of maintenance of its own culture, language, traditions is associated including those concerning reproduction of the population and traditions of ethnic upbringing representing without doubt cultural value.

Summarized results according to professional occupation of parents of schoolchildren reveal equal groups of employees and unemployed persons (37,7% and 38,5% respectively), clerks 23,8%. Correlation of workers and unemployed is 1,3 in fathers and 0,76 in mothers. Analysis of professional occupation shows high level of unemployment among parents of schoolchildren without significant differences in mothers and fathers.

Summarized results of educational level of parents of schoolchildren show that the most

prevalent one is secondary education (60,8%). To equal extent secondary special (18,1%) and not finished high and high education (18,6%) have been represented. Comparison of educational level according to sex shows predominance of secondary education in fathers (66,7% vs. 56,3% in mothers) and secondary special education in mothers (23,8% vs. 10,5% in fathers). To equal extent high education has been represented (16,7% in fathers and 16,6% in mothers). It is worth to notice that parents with high education, basically, were related to age 40-50 years and older than 50 years. Among young parents (up to 30 years) Secondary education was predominant. We may suppose decrease of real possibility of acquisition of high education for peasants by birth in the period of the last decade. It is possible also that the persons of young age with completed secondary special and high education do not strive to return into the village. The above mentioned determines relevance of the problem of attraction of young specialists into the village and creation for this appropriate conditions.

Epidemiological examination of children of a rural secondary school has revealed prevalence of clinical forms of borderline neuro-mental disorders (BNMD) being 30,1 per 100 schoolchildren, pre-nosological forms of BNMD have constituted 13,1 per 100. Ratio between taken into account pathology and the revealed one has constituted 1:6,5. Clinical structure of borderline neuro-mental disorders does not have ethnic specific and is represented by the following disorders: disturbances of psychological development F8 - 34,6%; behavioral and emotional disorders (F9) 29,5%; organic brain impairment-related disorders, and mild mental retardation of exogenous genesis (F06-07, F70) – 21,8%; neurotic and somatoform disorders (F41-45, F48) – 14,1%.

Investigation of factors exerting influence on formation of neuro-mental disorders in children and adolescents belonging to different ethnic groups allows avoiding the diagnostic mistakes and facilitates development of a complex approach to their timely treatment, rehabilitation and prevention. For fulfillment of these tasks we have used methods of multidimensional statistics (method of main components (MMC), factorial and discriminant analysis), that allowed revealing the most significant factors and their associations in multidimensional space of signs. Of the greatest significance were following ontogenetic clinical-psychopathologic and social-psychological compounds. Of ontogenetic signs we have presented characteristics of the period of early development, of significance were signs of perinatal pathology, psychodisadaptive episodes in anamnesis (enuresis, tick and speech disorders, fears, somnambulism in various combinations) and experienced diseases, in particular, craniocerebral traumata, intoxications, heavily flown infections and somatic diseases. Of clinical signs high and associated factorial loadings show totalities of characteristics such as deviations of behavior, pathological habitual actions, characterological features (excitability, aggressiveness, anxiousness, hypochondria), presence of accompanying somatic disease and manifestations of school disadaptation (poor progress in learning the program, low productivity, negative attitude toward the study, disturbed interrelations with peers). Maximum expressed factorial loadings fall on social-psychological characteristics: conditions of upbringing (hypoprotection, emotional deprivation); absence of work in parents; alcoholization of parents, especially of mothers; disturbed structure and function of the family (conflicts between members of the family, predominance of maternal upbringing, upbringing beyond the family), disturbed adaptation at child preschool institution.

In groups we find both differences and similarity in combination of signs. So in both groups a high loading has been shown by the factor "late children" that includes signs – number of the child according to birth (last child in family having many children 7-12 children), age of parents (average age of fathers 63+7,1 years, average age of mothers 55+5,9 years). In group of girls differently from boys its own contribution is made by such a sign as "regional morphodysplasias small anomalies of development" that in clinical expression were associated with pathology of residual-organic genesis.

Of more significance in girls was such a sign as "long-term and frequently ill children", presence of an accompanying somatic disease. For both groups a significant contribution is made by factors of pathological types of upbringing and addictive problems in parents.

Thus, carried out statistical analysis of 91 signs in two groups of schoolchildren has allowed obtaining the reliable factors exerting influence on mental health and creating matrix of data contributing heavily into possibility of polymorphic assessment of psychopathologic

disturbances of child-adolescent contingent of school age.

As a whole, in spite of some differences between boys and girls we may state that in development of psychopathology of childhood and adolescence similar sets of signs contribute – ontogenetic and social-psychological those determine peculiarities of clinical-psychopathologic signs. Social-psychological one differ according to content of compounding manifestations and are conditioned by ethnocultural peculiarities but remain similar according to their definition.

Assessment of obtained results shows that all signs contributing to development of psychopathology (i.e. risk factors) and signs decreasing this possibility (i.e. factors of resistance) may be divided into social, biological and cultural-psychological ones.

Social factors are divided into macrosocial, reflecting state of economic development as a whole, and microsocial, reflecting conditions of family functioning (composition of the family, number of children, pathological types of upbringing, character of interrelations in the family, participation of parents in upbringing, presence of addictive problems in parents, upbringing beyond family, upbringing by relatives).

Of not lesser important for schoolchildren is such an institute of socialization as the school that plays substantial role in both successful adaptation and disadaptation of the individual. High factorial loadings have such indices as academic progress, attitude toward study, school disadaptation, relations with peers, disturbance of behavior, day regimen. The above listed factors are closely associated with ethnocultural values, orientations and inherent economic activity.

The second block of signs is biological, including such signs as early development, perinatal pathology, experienced diseases, and episodes of psychodisadaptation in childhood, accompanying somatic pathology at the moment of examination. The third block of signs is cultural-psychological including characteristics: characterological features, relations with peers, relations in the family, attitude toward parents, and disturbance of behavior. In broader meaning these features may be correlated with ethnopsychological ones: attitude toward the older in age (parents and teachers), degree of severity of acceleration, differences in upbringing an expected behavior of boys and girls.

Differences of clinical manifestations of borderline psychopathology in Buryats and child-adolescent contingent of other populations are greatly contributed by social and psychological factors; of lesser specific influence are biological ones. Elucidation of the content of these factors and conditions for their realization is possible only from position of existing in this population culture, traditions and way of life. Such an approach will allow carrying out the activities on creation of conditions for leveling of risk factors and realization of factors of resistance that may serve as a basis stabilizing mental health in this or that ethnos.

Revealed regularities (trends) may serve as preconditions for creation of stable strategy of assessment and prevention of mental disorders in the ethnos. Final confirmation of this position is possible under conditions of long-term monitoring of mental health of investigated populations and as compared with data obtained during carrying out the analogous investigations in other ethnic groups.

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Transcultural approaches in adaptation in schizophrenic patients

A. Semke (*Russia*), L. Rakhmazova (*Russia*)

During last 25 years we studied problems of adaptation of schizophrenic patients, i.e. process of adjustment of patients to changed illness-related conditions of functioning (Jablensky, 1995; Semke, 2001; Korolenko, Dmitriyeva, 2000; Gurovich et al., 2003; Vid, 1993). We have revealed that adaptive behavior takes shape of totality of clinical and social factors among which ethnocultural ones occupy a special, organizing value and flowing against the background of serious biological changes in the organism and only in the half of patients we have noticed parallelism in their development (Fomin et al., 2006; Churkin, 2007).

We have distinguished 4 types of adaptation: integrative, with relatively high level of clinical and social adaptation; destructive, with opposite according to sign combination, as well as types of adaptation with dissonance between these indices – extravert, with relatively high clinical and low social adaptation and introvert – in patients preserving social functioning in the worst clinical parameters) (Semke et al., 2007; Logvinovich et al., 1995).

In the number of clinical preconditions of adaptation of significance are positive psychopathological disorders, negative manifestations as well as provoking, accelerating and complicating course of disease factors. Degree of adaptive value of positive disorders depends on their rank predominating in the course of disease or character of "persistence". Namely in their structure preformed by illness basic cultural images find reflection. As an example we may present change of fibula of delusional symptoms. Social cataclysms of the 90th of the past century have given significant rise to archaic, "magic" forms of delusional experiences. Also growth of catatonic symptoms of schizophrenia has been noticed.

Adaptive value of negative disorders is associated with rank, area of impairment, correlation of quantitative-qualitative structure what may be called as endogenous transformation of the personality on which peculiarities of positive disorders in exacerbations and remissions, adaptive reactions and types of individual compensatory-adaptive defense depend. Combination of different in character, depth and area of impairment of negative disorders creates a new personality structure and is a ground determining: content, degree of severity and periodicity of positive psychopathological disorders in remissions; degree of disposition to decompensating influences with possible clinical consequences; character of secondary compensatory formations (short-term adaptive reactions and more constant formations – basic types of compensatory-adaptive defense). This new life stereotype of the patient and finely quality and level of social adjustment take shape depending on individual adaptive possibilities and totality of social conditions, i.e. internal and external preconditions.

The internal take shape from basic kinds of adaptive reactions in patients with various characteristics of negative disorders and level of involvement into social processes in remissions: ignoring (anosognostic, hypertensive); hyperbolized (panic, hypotensive, atonic); adequate or plastic; not differentiated (selectively or corruptly tonic). The external take shape from basic kinds of attitude toward the patient of his/her nearest (loyal, passive-expectative, extremist) with which participation over time adaptively significant totalities of social-environmental influences take shape: hyperprotection, deprivation, formal of differentiated support.

Provoking, accelerating and complicating factors can exert influence on the character of positive and negative disorders, increase progression of the process and prevent the therapy, i.e. worsen clinical preconditions, exogenous adversities, somatic and neurological diseases, factors evoking decrease of immune reactivity or preventing effective biological therapy of schizophrenia with traditional methods.

Questions of prevalence of schizophrenia, factors determining structure and formation of this pathology, its course and outcomes continue to remain leading in epidemiology mental diseases (Eaton et al., 1988; Novikov, 2009; Semke et al., 2008). Knowledge of basic trends and regularities of change of this situation will promote resolution

of issues of program-target development of medico-sanitary services of specialized character.

Climatic-geographic, social-demographic peculiarities of districts of Siberian region exerting influence on mental health of the population and reflecting on indices of prevalence of psychiatric pathology in population determine relevance of investigations devoted to study of mental diseases including schizophrenia in "space and time" on some administrative territories of Russia and Siberia (Artemyev, 2007 et al., Vorsina, 2009, Semke, 2009).

Four groups of factors are distinguished determining state and dynamic of mental health of the population. These are as follows: level of development of psychiatric assistance, principles of its organization; inner conditions of development of the illness; social factors, natural and man-made environment. Thereby, health is biosocial essences of interaction of man and the environment, when direct and opposite relationships of man with environment is active and carries adaptive character.

For performance of the basic task of the investigation we have carried out the analysis of data on mental health of the population of republic of Buryatiya where poly-ethnic peculiarities of Siberian region have been presented most strongly. We have analyzed both data of statistical account and data of expedition investigations. Great significance during study of prevalence of mental diseases is acquired by the fact of long-term joint living on one territory of representatives of various nationalities when laws of crossbreeding, acculturation become effective. Furthermore, under pressure of industrialization in some representatives of the aboriginal population loss, destruction of life stereotypes, religious and moral-ethical notions happens. All this requires knowledge of culture, traditions, customs, history of development of the ethnos, its evolution that will help in establishment of approximated to real ones indices of prevalence of mental diseases in this population. A special value is acquired by these problems during revealing the mental disorders when attitude of the society toward manifestations of mental diseases becomes one of the leading because it can fluctuate from permissive to severely constraining. Poly-ethnic composition of the population of republic of Buryatiya dictates necessity of study of prevalence of mental diseases in the context of ethnopsychiatry.

All rayons of republic were conditionally divided into three groups with account for predominant (in quantitative relation) national composition of the population. As a whole we may tell that we have noticed relatively stable state according to average indices of taken into account schizophrenic patients on territories with predominantly Russian population while in population with predominantly Buryat population growth of this index continues.

Other picture is introduced according to dynamic of indices of sickness rate with schizophrenia. In rayons with relatively equal correlation of Buryat and Russian population we notice trend toward decrease of indices (16,3 and 14,3, in respective years). In rayons with predominantly Buryat population we observe trend of growth of this index. On the territories with predominantly Russian population line of trend remains plain throughout it.

Growth of national self-consciousness in representatives of various nationalities living in Russia reinforces the interest not only in folk medicine, religion accepted by this culture but also in occult-mystic directions what is promoted by social-economic and political instability of the society. For consideration of this question we have carried out a day census of schizophrenic patients in republican psychiatric hospital of Ulan-Ude of Buryatiya. One of questions of the census concerned search by the patient for assistance during rise of signs of the disease. We asked for time of the first contact of the patient with psychiatrists and search for assistance of aboriginal healers during rise of mental disorders. Questions were asked from patients, in some cases, relatives.

In the group of patients addressing healers, predominant majority has been represented by women. As rule they visited priests of various confessions irrespective from denomination. Russian women equally with addressing the shamans, lamas, priests visited healers. 22% of Russian women in parallel with addressing the healers sought assistance of general practitioners. In Buryats this index is lower (11%). As a whole, practically all women irrespective from nationality visited healers and physicians of various specialties beyond psychiatrists.

Men of both nationalities only under influence of relatives addressed priests. In single cases Russian men have visited datsans and nobody addressed shaman.

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Standard Symposium (SS-VI-27)

Transcultural Aspects in Clinical Assessment, Diagnosis and the Treatment of Immigrants and Refugees. An European Perspective

Chair: R. Al-Baldawi (*Sweden/Iraq*); Cochair: K. Laban (*The Netherlands*)

Immigrant living in extreme situation. Immigrant syndrome with chronic and multiple stress (The Ulysses Syndrome)

J. Achotegui (*Spain*)

Today, the circumstances in which many immigrants come to Europe present stress levels of such intensity that they exceed the human capacity of adaptation. These persons are, therefore, highly vulnerable to Immigrant Syndrome with Chronic and Multiple Stress, known as the Ulysses Syndrome (in reference to the Greek hero who suffered countless adversities and dangers in lands far from his loved ones). The most important stressors are the enforced separation of the one's loved ones, the failure to achieve one's objectives, the experiencing of extreme hardships and terror. Furthermore, the stressors are chronics and without network of social support. What's more, the health system often does not provide adequately for these patients: either because this problem is dismissed as being trivial or because this condition is not adequately diagnosed and immigrants are treated as being depressive or psychotic, thereby giving the immigrant even more stressors to face.

The symptomathological expression of Ulysses Syndrome is a specific combination of symptom of the area of depression, symptoms of the area of anxiety, somatic symptoms and confusional symptoms. To this symptomatology is often added an interpretation made from the perspective of the subject's own culture. The Ulysses Syndrome forms a gateway between mental health and mental disorder The Ulysses Syndrome is found in the area of preventative health care and the psychosocial sector more than in the area of the treatment. Loneliness, fear, despair ... the migrations of this new millennium remind us increasingly of Homers' verses " ... But the days found him sitting on the rocks, torturing himself with tears, and heartache, and looking out with streaming eyes across the watery wilderness..." (Odyssey, Song V, 150,) and the part of the text in which Ulysses tells Polyphem: "You ask me my name. I shall tell you. My name is nobody and nobody is what everyone calls me" (Odyssey, Song IX, 360). It is clear that if a man has to become a nobody in order to survive, if he has to remain permanently invisible, he will have no identity, will never become socially integrated, self-esteem, nor will he enjoy mental health.

Psychosocial consequences of the accumulated migration related stress. Clinical observations on a group of recently arrived Iraqi refugees to Sweden

R. Al-Baldawi *(Sweden/Iraq)*

More than 4 million Iraqi people are forced to leave their homes and seek protection in other places. More than 2 million of them have fled to neighbouring countries such as Jordan, Syria, Iran and Turkey. A small amount of the refugees are provided with the possibility to seek asylum in different parts of Europe and other countries around the world. More than 60,000 Iraqi refugees have fled to Sweden since 2003. Approximately 40,000 of these have been provided with residency, while the remaining refugees are still waiting.

The movement from one country to another comes with a number of different challenges for immigrants and their families. Encountering the new country's socio- cultural structure is just one example of the many new waves of challenges met

by these immigrants. Learning a new language; finding a job adequate to the individual's education and experience, belongs to these challenges. For some immigrants the challenges within the adaptation process can involve new trauma or enhance the old trauma the individual has with them. The Migration related Stress is the sum of many factors which take place in the individual's life within migration process all phases (native country, transfer, and host country phases). Many immigrants succeed to recover this kind of accumulated stress, but some of them develop a high number of psychological and social reactions in their adaptation process.

This presentation based on clinical observation and interview with a group of 40 adults recently arrived Iraqi refugees to Sweden that are admitted to our centre for treatment and psychological support. Long term exposure of stress, fear and accumulated traumatic situations influence the newly arrived refugee's psychosocial life and rise up a number of psychological and social problems and make it difficult for them to commence an active life in the new country.

A resilience-oriented theory and practice model in the treatment of traumatized refugees. Experiences from a regional centre for transcultural psychiatry

K. Laban (*The Netherlands*)

Background

The use of a resilience-oriented approach in the treatment of patients with complex social psychiatric problems, like asylum seekers and refugees, needs more attention. Focusing on resilience in the treatment setting implies a shift from focusing on symptoms to enhancing recovery (from complaint to strength).

Method

In a short overview prevalence rates of psychiatric disorders and pre-and post migration stress factors in asylum seekers and refugees are shown.

Subsequently the concept of resilience is explained and a resilience-oriented working model is introduced. The model contains four elements: stress, vulnerability, strength and social support. It was first described by De Jonghe et al. (1997) and recognizes the multi-factorial aetiology of psychopathology and puts emphasis on the importance of personal strength and potentials of recovery. The model is build on the well-known stress-vulnerability model from Zubin and Spring, 1977; Ingram & Luxton, 2005). The four elements work in relationship with each other. This model has been the foundation of the diagnostic and treatment procedures in the "Evenaar" – the Equator - Centre of Transcultural Psychiatry North Netherland since 5 years and it has proven its value in a multicultural treatment setting. A short overview of the literature on resilience is given and biological, psychological, social, cultural and religious resources of resilience will be explored (Southwick et al., 2005). Several resources will be discussed in more detail and the presentation will be illustrated with some cases.

Results

Patients, but also mental health workers benefit from a resilience-oriented approach. Health workers will be less overwhelmed by feelings of powerlessness, which is so often the case, especially in the treatment of asylum seekers. Patient have a higher chance to become stronger (physically and emotionally), to increase their problem-solving competence and to lessen their functional disability. All kind of more specific therapies can be embedded in this general treatment approach.

Conclusion

More attention for resilience factors is advised in clinical and research setting that focus on patients and populations who experienced 'adverse life events'. The clinical experiences are encouraging. When patients are able to find (again) their resources of resilience the possibilities of mental and physical recovery increases substantial.

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Tortured refugees in treatment. A challenge for psychiatry and rehabilitation medicine

H. Rohlof (*The Netherlands*)

Research in our centre for the treatment of traumatised refugees shows that torture is quite common: 65 % of the refugees have undergone torture in earlier life at least once. In these tortured refugees many somatic complaints occur, next to their psychopathology: headache and backache are among the most common complaints. Even more interesting is that in non-tortured refugees the score on somatic complaints is not lower!

This high amount of somatic complaints demands another strategy in treatment than in other patients. This is the reason that we decided to start a new project in our centre for tortured refugees. In this project we combine psychiatric and psychotherapeutic treatment with treatment in rehabilitation medicine. In rehabilitation medicine somatic examination can be done, and somatic therapies against pain and function loss can be given. In psychiatry and psychotherapy specific transcultural trauma treatments can be administered.

This strategy can serve as a model for more transcultural treatments, where somatization plays a role.

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Standard Symposium (SS-VI-28)

The Sacred has to be Sought in Tiny Details

Chair: M. Ascoli (*UK/Italy*); Cochair: M. Tartari (*Italy*)

The dark night of the soul. Causes and resolution of emotional distress among contemplative nuns

G. Durà Vilà (*UK*), S. Dein (*UK*), R. Littlewood (*UK*), G. Leavey (*UK*)

An ethnographic study was conducted in the Spanish Monastery of Santa Mónica (this is a pseudonym in order to keep the anonymity of the nuns) whose community consists of ten contemplative Augustinian nuns. Through participant observation and interviews the stresses encountered and the strategies deployed to cope with them are explored in depth. It was clearly found that symptoms that otherwise might have been described as pathological, along the lines of a depressive episode, and treated accordingly, were understood by the nuns within the framework of the so-called Dark Night of the Soul narrative: an active process of transforming emotional distress into a process of self-reflection, attribution of religious meaning and spiritual growth. We conclude by discussing its clinical implications, highlighting the importance of incorporating existential issues into clinical practice.

Outline of the study

In this article we argue that to giving due importance to existential issues is crucial in developing the right understanding of a variety of symptoms developed by the nuns who were the object of our study. We support this thesis chiefly by exploring the centrality of the experience of emotional distress that has become known as the Dark Night of the Soul. Its importance is two-fold: on the one hand, it provides a salient example of the need for taking into account existential matters when assessing seemingly pathological symptoms; on the other, it provides a very good route to understanding the coping strategies that are found in relation to other sources of emotional distress in the lives of the nuns.

Furthermore, although part of the interest of the present work lies in the nature of the community under study, we also believe that - partially, but relevantly - some of our findings with regard to the importance of existential issues in the evaluation of prima facie pathological symptoms, can be extrapolated to people with religious beliefs who do not live in a monastic community.

It should be noted out that ethnographic field work on nuns and monks is scanty. Finding religious communities willing to engage in the process of ethnographic research is difficult, with anthropologists' requests for fieldwork being frequently rejected (Reidhead, 2002). Hillery (1992) attributes the scarcity of social scientists in the field of Christian monasticism to the demanding nature of the research methods required. Participant observation and interviews can be perceived as too intrusive by the monastic communities.

This study is the first one that - to our knowledge - has used the methodology of applied ethnography to explore Catholic nuns' experience of emotional distress, their perceived causes and coping strategies; moreover, these Sisters are contemplative (cloistered, leading a life devoted to prayer secluded within the walls of the monastery) unlike the ones in previous studies who belonged to active-life orders (who work in the world in the service of others). In addition to these differences, they are facing a severe decline in vocations that is seriously threatening the continuity of their way of life, while developing countries (where most of the preceding ethnographies were undertaken) are experiencing a rise in the number of entrants.

This paper outlines an ethnographic study of the Monastery of Santa Mónica which examines the stresses encountered by the Sisters and the strategies deployed to cope with them. We shall discuss the various forms of coping through the perspective of the literature on religious coping, more specifically describing how the nuns' coping strategies can be understood in terms of the idiom of the Dark Night of the Soul. The clinical implications are highlighted.

Participants and methodology

The participants of the study consisted of the ten contemplative nuns living in the Spanish Monastery of Santa Mónica who belong to the Order of Saint Augustine. The Sisters' ages range from 21 to 76. In order to keep the anonymity of the nuns, the exact name of their monastery and its location are withheld.

Fieldwork was conducted from July 2006 to June 2008 in seven visits approximately four months apart to the Monastery of Santa Mónica in Spain. The visits lasted an average of two days each. In addition to these, I attended a ceremony of profession of Perpetual Vows of one of the Sisters and held a collective meeting once the analysis of the data was completed to validate the findings.

Ethical approval to undertake the study was granted by University College London, Research Ethics Committee. After explaining the project to the Mother Superior, each nun was asked to give informed consent.

Tape-recorded semi-structured interviews were deployed in the study lasting an average of an hour. They were conducted by the primary author in a room of their guesthouse. The majority of the interviews were conducted in Spanish, and two in Catalan, without an interpreter, and were all transcribed verbatim for the purpose of the analysis. The questions for the semi-structured interviews were chosen after pilot interviews with them. The Sisters discussed extensively their experiences of emotional distress, the stressors encountered in their lives and their specific ways of coping with them. A detailed portrayal of the Dark Night of the Soul and an overview of the core aspects of their monastic life were also obtained through systematic inquiry in the interviews. In addition to semi-structured interviews, participant observation was another important source of data collection as I carefully observed the nuns in different settings (predominantly, in their chapel, guest house and garden). Additionally, I had multiple informal conversations with the nuns.

Content analysis of the data was carried out. The transcripts were thoroughly read by the primary author. Relevant statements from the transcripts were highlighted, and themes were derived from those statements. Themes drawn from each interview were compared across transcripts looking for recurring themes which were subsequently categorized, providing a synthesis of multiple interviews into thematic categories. Each theme was built upon a considerable number of narratives and information. The themes extracted from the data represent the key findings of the study.

Several strategies were employed to establish the trustworthiness of the results. The long contact with the Sisters, stretching over almost two years, enabled me to clarify and expand emerging themes, as data collection and analysis overlapped. Some of the transcripts were also independently read and analyzed by a researcher with experience in theology and anthropology to assess the robustness of the themes. The Mother Superior, the Mother Accountant and the Mother Teacher were re-interviewed to deepen the information about the themes elicited. Respondent validation was obtained through a collective meeting held once the analysis was completed at the end of the study to corroborate the main findings by the nuns themselves.

Emotional Distress and the Dark Night of the Soul. Causes and Coping Strategies

The sources of emotional distress that the nuns face in their lives and the specific strategies deployed in coping with them are described. We have paid particular attention to the Dark Night of the Soul. Some of these strategies were mentioned in connection with several stressors. Therefore, for the purposes of clarity, the coping strategies have been paired with the cause with which they were most frequently linked. The importance of the Dark Night of the Soul as a model of religiously motivated coping strategy is highlighted here and is further developed in the discussion.

It was common to hear the Sisters using the expression 'La Noche Oscura del Alma' (Dark Night of the Soul) to refer to the experience of profound spiritual suffering and desolation. This term comes from the title of the sixteenth-century Spanish classic poem with the same title written by the Carmelite priest Saint John of the Cross in which he described the arduous path traveled by the soul to reach mystical love. The Sisters considered this period of spiritual angst and suffering to be a natural - not pathological - stage of the spiritual development, intrinsically associated with a process of personal growth and maturation. All the nuns had undergone a period of spiritual darkness at some point in their lives. The Sisters' depictions of their Dark Night have many similarities, in both their symptoms and attribution of meaning. The most extraordinary account of the Dark Night was that of Sister

Teresa (pseudonym), due to its length - lasting 'at least ten years' - and the depth of her suffering began around the time she entered the monastery when she was 21. Her narrative serves as an illustration of the characteristics of the Sisters' Dark Night of the Soul.

In the analysis of the Sisters' narratives, we could observe clearly three key elements: (a) a number of seemingly pathological symptoms, which bear great similarity with or are identical to those ascribed to depression (e.g., tearfulness, low mood, lack of volition, loss of appetite, etc.); (b) behavioural patterns and emotions which do not correspond to depression (maintenance of activities, sociability, preservation of hope, optimism despite the frustration, etc.); and (c) an attribution of meaning (religious meaning in the idiom of the Dark Night of the Soul) which facilitates (b) in spite of (a).

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Satanic ritual child abuse in Italy. Iatrogenic factors in the minors' judicial iter between cultural, moral and scientific issues

M. Tartari (*Italy*)

This paper reviews the phenomenon of satanic ritual child abuse and his arising in the last ten years in Italy.

An exemplary case and its development allow to examine the born of the allegations, the assessment of the children as witnesses and the iatrogenic factors for the minors involved in the trial.

Different point of views about the child as a witness among different currents of forensic psychologist don't share assessment methods of the supposed sexual abuse victims. Recent Italian psychological guidelines – reviewed in this paper – are the first attempts for setting limits to this professionals' discretionary power.

Psychological and sociological perspectives allow to analyse the phenomenon of satanic ritual abuse between moral and scientific issues, professional ethics and not ethics behaviours.

Risk Society (Beck 1992) and culture of fear are a possible backdrop for the origin of these cases.

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Pictures of Jesus

F. Zanatta (*UK/Italy*), S. Dein (*UK*), R. Littlewood (*UK*)

"*An interpersonal relationship is always a mystery; it is more when it involves a relationship with God; when the relationship is between God and the child the mystery is greater still*"
(Cully, 1980)

The research presented in this paper has been developed to achieve an insight on the concept of God in children, from a Catholic community in North-East Italy, and its influence in their everyday life.

Starting from the meaning of religion, the literature review is developed into three sections, each focusing on different aspects of the connection between religion and children. The first part is the analysis of various studies on the origin of religious feelings in children. Elkind (1970) and Cavalletti (1983) are here considered as the representatives of the two sides of the discussion: religion as answer to specific needs versus religion as innate feeling. The second section summarises the main theories which analyse the religious development in children, contrasting those deriving from a Piagetian background with those proposed by psychoanalytical authors. The last section introduces various studies that investigate the image of God in a psychological context. Starting from the discussion on the religious sense of guilt developed first by Freud and then expanded by Vergote, to then move into new areas of research, such as the analysis of the correlation between the image of God and parental images, transitional objects, and attachment.

The methodology applied to collect and examine data has been decided according both to the aims of the research and to the requirements of working with children. Therefore it has been preferred a method less related to the traditional psychology. Projective tests, test batteries and questionnaires, previously adopted in researches on children religiosity in Italy (Vianello, 1976), have been avoided in order to approach the children as subjects rather than passive objects. One of the aims of the study was to achieve the active participation of the children to enable them to express their own point of view and experience. For this reason two different approaches have been applied in the conduction of the interviews. During the first part of the study all the thirteen children have been asked to complete a semi structured interview on their religious concepts, followed by a drawing task. In the second part the researcher fully discloses the aim of the study to some of the children (involved in this section according to their availability), to then ask them few more questions specifically focused on their personal relationship with God.

During this second meeting the children have also been asked to become the researcher and to discuss and interpret the interviews and the drawings of the other children.

The results are an insight into the personal relationship child-God, bearing in mind that the image of God is an extremely personal experience, determined by the encounter of inner and external forces and dynamics. However six common themes have been identified through the systematic analysis of the interviews.

The first theme is the interconnection between God and the child's identity. Similarly as in Rizzuto's (1991) theories on the deity as an internal object, the children demonstrated a tendency to either identify the deity as a part of their self or let the deity to shape their identity.

Then the differentiation between the images of Jesus and God, described as two separated figures having completely different roles and impacts on children's life. On one side Jesus as the concrete friend belonging to a world of actions, on the other side the terrifying God belonging to a world of abilities and powers that can hardly enter in connection with the child's real world.

The confusion and insecurity emerged in the second theme is the main feature of the third in which the children discuss their concept of the celestial family.

The discussion then moves onto children's doubts, their nature and meaning with the identification of four kinds of doubts: metaphysic, for convenience, for lack of comprehension, and for confusion.

The mind-heart dichotomy in the child and in God and the reference to books and stories are the last themes deriving from the analysis of the collected data.

The most interesting findings obtained from the analysis of these themes are however related to the needs that urge the child on asking God's help. Inserting all these information in the child's

context the effects of God's image on the child's well-being appear way clearer. In children's hands the image of God becomes almost a tool used to solve problematic situations: from feeling part of a community, to explaining the loss of a brother; from realising the will to improve your skills, to feel safer.

Even from the data deriving from the second part of the research God appears as a detached, hardly reachable tool who cannot compete with the warmth and the physical presence of Jesus. Anyhow as stated before, every child has a unique relationship with God and therefore the influence of this present varies. An accurate analysis of the specific case is necessary to obtain valid results.

In reading these outcomes it is necessary to keep in mind the socio-cultural context surrounding and shaping the informants' lives and that inside the themes it is possible to find various nuances for every child

This study is not as a defined, static and closed work, but instead as a work in progress; a work that can be enriched by the reader's personal experience and by his/her willingness to enter the children's world.. For this reason the aim of this research is to sit and listen, not just the worlds, but also everything that is behind them.

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End of life decisions and the cultural relativity of values. An Italian case of mass hysteria

M. Ascoli (*UK/Italy*)

On the 9th of February 2009 Eluana Englaro, a woman who after a car accident had been in a persistent vegetative state for 17 years, died as a result of the interruption of all IV hydration, artificial nutrition and supportive treatments, which occurred after a long legal battle fought by her father.

The Englaro case, on which Ita'089lian media focused throughout 2008, prompted a heated debate within the Italian public opinion. The debate gradually escalated in a confrontation between those supporting the decision to stop all treatments (mainly individuals, associations and political parties from a lay background) and those supporting the cause of keeping Eluana Englaro alive, even in a persistent vegetative state and against her expressed will (the Catholic Church, the Italian Government and several religious associations and charities).

The escalation of this debate culminated in a clash between two opposite and irreconcilable conceptualizations of the meaning of life, death and the rights of the individual, expressed at times through mass hysteria-like phenomena, of which the Author will bring visual examples.

After a brief account of the main facts, the Author will offer an explanation of this case scenario as an example of religious fundamentalism in a Western country and will use this case as the basis to illustrate some formal characteristics of religious thinking processes.

Standard Symposium (SS-VI-29)

Psychological Assessment and Care of Children and Adolescents in Different Cultures

Chair: I. Lopez (*USA*); Cochair: M. Soltan (*Egypt*)

Prevalence of obsessive compulsive disorders in female secondary school students in Cairo

Z. Bishry (*Egypt*), G. El-Nahass (*Egypt*), E. Abou El-Ela (*Egypt*), M. Soltan (*Egypt*)

Our study aims to estimate the pinpoint prevalence of obsessive compulsive disorder, and subthreashold obsessive compulsive syndrome in Egyptian females during the adolescent period. The study also delineated the commonest OC symptoms in our culture that may be different from adults.

The study was conducted on female secondary schools in Cairo. It covered urban, semiurban and rural areas and public and private schools, the total sample included 607 students. Two stages design was applied, first: the screening phase using Leyton obsessional inventory-child version. Second: candidates who were considered positive for obsessive compulsive symptoms were subjected to MINI-Kid to diagnose cases with obsessive compulsive disorder and the associated comorbidity. It was found that the point prevalence of OCD is 1.2%, and that for sOCS is 13.01% these values were not significantly affected by order of birth, religion, residency, or socioeconomic state .The mean age for OCD was 14.42 while that for sOCS was 15.15. The commonest OC symptom was excess conscience being significantly commonest in rural area (pvalue=0.000) and similarly it was more common in public than private schools. Comorbid psychiatric disorder was detected in all cases of OCD, dysthymia and non OCD anxiety disorders were the most common. To conclude, OCD as well as subthreashold obsessive compulsive symptoms are common in adolescent females, presented most commonly with excess conscience and they have the same comorbidity pattern.

Ataques de nervios and its psychiatric correlates in Puerto Rican children from two different contexts

I. Lopez (*USA*)

Among Latino adults and children, ataques de nervios has been associated with an array of psychiatric disorders. Using data from a probability sample of Puerto Rican children, aged 5-13 years (N = 2,491), we assessed the lifetime prevalence and psychiatric correlates of ataques in youth residing in the South Bronx, New York and San Juan, Puerto Rico. Baseline site comparisons indicated that between 4-5% of children had a lifetime prevalence of ataques (either by child or parent report) and that ataques were associated with greater global impairment and a host of childhood disorders within the previous twelve months. Ataques were also correlated with greater exposure to violence, as well as more stressful life events for the South Bronx sample. After controlling for several covariates, ataques continued to be significantly associated with psychopathology. Ataques are, therefore, a significant correlate of global impairment and childhood psychopathology among Puerto Rican youth.

Ethnic variation in service utilisation amongst children with intellectual disability

M. Hodes *(UK)*, G. Durà-Vilà *(UK)*

Background

The impact of having a child with intellectual disability (ID) is influenced by the sociocultural context in which the individual lives (O'Hara & Bouras, 2007). This arises because of cultural variation in beliefs about the learning disability, and different living and care arrangements, alongside economic factors.

Furthermore, the frequently associated physical health problems are also subject to similar influences (Helman, 2007). However, whether there actually is ethnic variation in service utilisation for people with ID and especially children has not been adequately investigated. Within the UK context, it has been claimed that South Asian families caring for individuals with ID may under-use services (Baxter et al., 1990). A cross-sectional study compared the rates of psychological morbidity and service use among South Asian and White adults with ID in Leicestershire (UK) (McGrother et al., 2002).

Although South Asians showed similar levels of psychological morbidity, they made significantly lower use than Whites of psychiatric services, residential care and respite care. Nearly twice as many South Asians adults with ID lived at home with their families compared with White adults. South Asians may make less use of residential care than white British (Fatimilehin & Nadirshaw, 1994). Data is entirely lacking with regards to children with ID.

Differences in family structure existing among ethnic groups may contribute to variation in service utilisation (two-parent families may be better able to provide care). In the UK, all South Asian ethnic groups (Indian, Pakistani and Bangladeshi) have higher proportions of multi-adult and fewer single households than Whites.

Black-White mixed heritage, African Caribbean and Black African ethnic groups have higher proportions of lone parent and single households than other ethnic groups (about half of African Caribbean children are living with only one parent, compared to a sixth of children nationally) (Modood, 2005; Markkanen, 2008).

The main aim of the current study was to investigate possible ethnic variation in uptake across child and adolescent mental health and social services taking into account the impact that family composition and support may have on service uptake. Subsidiary aims were to investigate variation of provision in physical and education services.

Method

A survey was carried out in four special schools in London. Information was provided by school teachers using case files, and 242 children aged 7 to 17 years with mild and moderate ID were identified. Ethnic categories were derived from self-reported main categories. Service utilisation was categorised as use of: child and adolescent mental health services (CAMHS), social services, physical health and education services.

Pearson Chi-square and Fisher's exact tests with 95% confidence intervals were s used, depending on the size of the cells, in the analyses to compare the data collected amongst the six ethnic groups ('6 x 2' table). Binary logistic regression was also undertaken to identify for variables which may predict service uptake.

Results

CAMHS uptake was lower for South Asians than for White British (P = 0.0487). There were statistically significant differences amongst ethnic groups for community-based social services uptake (being the highest for the Black groups and the lowest for South Asians, P = 0.015) and respite care uptake (being the highest for the Black and White European groups and the lowest for South Asians, P = 0.009).

Regardless of ethnic group, CAMHS and social services (community-based) uptake was statistically significantly higher for single-parent/foster families than for two-parent families.

In regression analysis family structure predicted CAMHS service utilisation and social service community support. Ethnicity predicted use of respite care.

Conclusions

Significant ethnic differences in service utilisation amongst children with ID were found

for both CAMHS and social service contact. There was particularly low service use for the South Asian group. These differences might arise because of differences in family organisation, as more South Asian children lived in two-parent families, which may have been better able to provide care than single parent families. Other factors such as variation in parental belief systems, and variation in psychopathology may be relevant. Implications are discussed.

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Standard Symposium (SS-VI-30)

Culture and Psychotherapy for the Chinese

Chair: J. Hsu (*USA*); Cochair: X. Zhao (*China*)

Chinese traditional medicine concept and psychotherapy

F. Tian (*China*)

Chinese traditional medicine is developed under the ancient Chinese culture background, therefore, its concept of health, illness, and treatment for sickness reflects the Chinese thought. This includes concepts how to heal mental problems.

The Chinese traditional medicine recognizes a person's mental activity as reflection of qing-zhi (emotion and will), a comprehensive reaction manifested by a person when he encounters and deals with the objective reality and interpersonal interaction. As early as 2000 year ago, it is recognized that a persona has seven basic emotions, namely: happiness, anger, worry, anxiety, sadness, fear, and terror. It takes the view that excessive emotion will cause sickness. It is the important reason of mental disease. It also explains the mechanism for the disease of feeling. As for therapy, it emphasizes how to maintain the balance among these seven emotions for obtaining the healthy mental state.

Regarding the therapy of mind, the following basic concepts and principles are emphasized, namely: (1) Tranquilization and calm is better than fidgety; (2) Keep the spirit inside of the mind, allowing the qi (vitality) flowing smoothly, then sickness will heal accordingly; (3) Adjust mood, to win (regulate) and balance excessive feelings by other feelings, and transfer those feelings, desires, and ambitions properly; (4) Maintain the proper and happy spirit, encouraging adequate relations with others, and keeping a sense of humor; (5) Regulate mental condition all the time, adjusting mental state according to the seasonal change, and to follow the principle and rhythm of nature.

These concepts and suggestions are useful in providing psychotherapy for people, particularly for the Chinese who are familiar with and perceptive to such traditional medical concepts.

Experiences of Daoistic cognitive therapy for the coronary heart patients

J. Zhu (*China*)

Coronary heart disease (CHD) is considered a psychosomatic disease which is closely related to mental tension. Epidemiological data shows that "common diseases" such as hypertension, diabetes mellitus, and obesity, as well as Type-A behavior may contribute to the frequent occurrence of CHD. All these common diseases are closely related to personal life style and daily behavior. Therefore, they are addressed as life-style disorders as well.

Daoistic Cognitive Behavior Therapy (DCT) has been developed in China over the past ten years. It is based on the Daoistic philosophy of life. It emphasizes the quality of inner emotional well-being, psychic detachment from competition and desire for achievement, resulting in spiritual freedom. Therapy is carried out through cognitive group sessions, combined with physical relaxation exercises.

DCT has been used for patients with different disorders. Clinical experiences have shown that it works well for elderly patients who suffer from coronary heart disorders because they have a tendency to over work obsessively throughout their lives. They will benefit greatly by the change of philosophical attitude to take it easy in their late life. In order to show that patients with CHD can be benefited by DCT, a study has been carried out.

Subjects and Method of Study

Patients with CHD who were receiving medical outpatient treatment in the Staff Hospitals of Changsha University of Science and Technology and Hunan University were recruited for the study. The inclusive criteria are: clinical diagnosis of CHD (according to International Society of Cardiology and World Health Organization criteria); and further laboratory positive evidence. Those suffering from a cerebral vascular accident, malignant tumor, high blood pressure, recent occurrence of myocardial infarction, a history of mental disorder and serious cognitive function disorder were excluded. As a result, a total of 206 patients were included for the present study. Their age ranged between 51 to 77 years with an average of 67. The subjects were divided into the (psychotherapy) study group (104 patients) and the control group (103 patients).

Patients in the control group received merely drug therapy while the (psychotherapy) study group received drug therapy plus DCT. The study group, for the sake of receiving DCT, was divided further into several small groups, about 10 patients each to receive the cognitive group therapy session. The session was one-hour each time per week, for the period of eight weeks all together.

The therapy was performed in the form of a group didactic session. It included several components, namely: (1) Teaching of the concept of Daoistic philosophy as condensed in eight phrases. (2) Analysis of the contributing factors for the development of CHD, and how to apply Doaistic philosophy into their actual life and to convert their life style. (3) Review of personal recordings made by the patients, for examining whether the patients were able to cope with the situation by following Daoistic philosophy or not. The practice of meditation and light physical exercise for body relaxation were performed together with the group teaching session.

Results

For the sake of evaluation, throughout the course of therapy, two forms of questionnaires, namely Type-A Behavior Questionnaire, and Mental Detachment Questionnaire were administered at pre-treatment stage, 3 months and 6 months post-treatment follow-up stages respectively. According to the Type-A Behavior Questionnaire, patients with value of TH+CH, more than 28, were considered having positive type-A behavior. The results indicated that the type-A behavior score decreased significantly for the (psychotherapy) study group than the control group by the follow-up study (*see Table 1*).

Table 1: *Comparison of type-A behavior score at the stage of pre- and post-treatment between (psychotherapy) study group and control group.*

Group/Stage of study	Psychoth. (n=92)	Control (n=87)	χ^2	p
Pre-treatment	44/48	39/45	0.162	0.688
3 months after treatment	24/26	35/40	1.526	0.017
6 months after treatment	26/28	35/40	1.463	0.021

The Mental Detachment Questionnaire was designed to determine to what extent a person can detach from a desire of competition and achievement, resulting in spiritual freedom, and achieving the Daoistic philosophical attitude. The higher score indicates the success in this regard. Comparison of score of (psychotherapy) study group and control group indicated that, the score increased for the study group but not for the control group (*see Table 2*).

Table 2: *Comparison of score of mental detachment the stage of pre- and post-treatment between (psychotherapy) study group and control group.*

Group/ Stage of study	Psychotherapy (n=92)	Control (n=87)	t	P
Pre-treatment	28.7±4.4	27.2±3.6	1.045	0.297
3 months after treatment	31.8±3.8a	27.0±3.6	8.506	0.000
6 months after treatment	32.6±3.1ab	27.0±3.4	11.371	0.000

a P<0.01,vs pre-treatment; b P<0.05, vs 3 months after treatment

The study indicated that DCT results in the significant decrease of Type-A behavior score and being able to achieve mental detachment from desire for competition and achievement for the patients treated. It may say that DCT was effective to change the behavior and life style of the elderly patients with CHD, which in turn is considered beneficial for them to reduce the risk of CHD.

Subjective-self and objective-self in psychotherapy for the Chinese

Z. Cong (*China*)

From a psychological perspective, a person's mind can be divided into two parts: the subjective-self and objective-self. The subjective-self represents feelings, desires, instincts and primary wishes, which is based on one's own need. In contrast, the objective-self represents reasonable thinking, logic, and an objective sense of self, with a more conscious regard of reality and concern for others.

During psychological development, a baby starts with their subjective-self, and there is no objective-self in the infant's mind before the "mirror stage". The infant becomes astonished at finding himself in the mirror around the age of one, begins to perceive and realize objective-self along with subjective-self. The subjective-self and objective-self are distinguished gradually in the child's mind until reaching adulthood.

From a mental health point of view, if a person's subjective-self and objective-self are balanced, there are less mental health problems. In general, patients with mental problems can not keep their subjective-self and objective-self well balanced. Some of them have a stronger sense of subjectivity and weaker concern of objectivity, therefore, they are prone to develop certain prominent self-focused disorders such as hysteria, schizophrenia, dementia, or anti-social personality disorder. On the other hand, some patients have a weaker sense of subjectivity and a stronger concern of objectivity, so they tend to suffer from neuroses, particularly obsessive disorder or depression. Psychotherapy, in a sense, is to help the patient to have their subjective-self and objective-self well integrated and properly balanced.

From a cultural perspective, the Freudian Theory developed in the background of western culture. Since the era of Socrates western culture has been upholding the importance to the reason and rational sense. The Freudian theory not only provided a unique method of psychotherapy, but it offered a revolution in western culture, because Sigmund Freud stressed unconsciousness at the level of subjective-self: paying more attention to the basic feelings and primary desires and wishes of the mind, the fundamental human nature underneath the rational sense.

On the other hand, the Object Relations Theory refers to a more objective-self, stressing the relational perspective of the object(s), making less concern towards the subjective-self. The Object Relations Theory stresses well differentiation of objective-self and subjective-self, making little concern of integration of them both.

From a comparative point of view, the Chinese culture stresses the subjective aspect of the mind more than western culture. According to ancient Daoism, every person is considered as a subject being, the harmonious relation of people to people, and the relation of people to the environment are also stressed. Laozi said that: "People follow the Earth, the Earth follow the Sky, the Sky follow the Dao, the Dao follow the Nature". It means that everything is changing according to nature. It is better to follow nature, making good use of your subjective-self, to doing things according to nature. It is opposite to the idea of the Socrates, to do things with a rational sense.

Confucianism carried on the philosophy of Daoism. Confucius said that: "Do not do thing to others for the things which you do not want others do to you"; "(As a human) try to do your best, accepting all the results as determined by the Heaven (the Sky)"; and "A man becomes firm without any desire".

Buddhism stresses how to utilize subjective-self for existence and freedom. Man can become free if he withdrew his libido toward an external object into his mind. Therefore, we should refrain from our desires. This is one of the basic characteristics of eastern culture. Both the musing and meditation are utilized as the mean for a man to return to his subject state with a deeper mind, integrating the subjective- and objective-self; and, at last, ignoring both others and himself.

This eastern view is very different from that of the rational sense-emphasized western culture. These Chinese culture-based psychotherapeutic elements can be used for Chinese patients, and make up the shortage of psychoanalytic or object relations theory.

Furthermore, commonly known sayings or proverbs can be effectively used for Chinese patients. As clinical examples: when a patient is not respectful to other people (lack of empathy), the therapist can make good use of the (Confucius's) saying of: "Do not do thing to others for the things which you do not want others do to you"; when a patient who has too strong of a desire to overrun other people, the therapist may offer the (Lao-tze's) saying of: "Following the Nature". If the patient feels hopeless, the therapist can advise the patient the common saying that: "The End leading into the Change; The Change leading to the Resolution; the Resolution leading to the Permanent Results". If a patent is too stubborn, being over preoccupied with the desire or thought, the therapist can provide the (Buddhism) concept of: "The pipal tree (under where the Buddha gets enlightenment) is not a tree; a brighten mirror is not a mirror; there is nothing existing but nothing; where will the dust of life come from? (no need to obsess about the desire). In a philosophical way, it is intended to communicate the enlightenment that: "There is nothing in the world; keep your mind empty; then your mind can be free".

In summary, we can say that: the Chinese culture stresses the subjectivity of the mind, emphasizing the integration of subjective-self and objective-self. This culturally based balanced approach can fetch up the shortages of western psychotherapy which emphasize either gratification of self or objective rational resolution for the problems. The subjective-self and objective-self balance psychotherapy can be used for Chinese patients who are familiar with such cultural concepts and will obtain better therapeutic effects.

Standard Symposium (SS-VII-31)

Victims of Cultures of War. What Can a Psychiatrist Learn?

Chair: H. Wahlberg (*Finland/Sweden*); CoChair: J.D. Kinzie (*USA*)

War and its consequences on women's mental health

M. Kastrup (*Denmark*)

Most societies have given women a subordinate position and many cultures still treat women as second- class citizens, under control of their fathers, brothers or husbands. Culture, traditions and beliefs allow various forms of violence against women, and war and collective violence affect the health of women disproportionately as societies subordinate women and under prioritise their life and health.

A great challenge is to minimize its negative impacts, by e.g. enabling women to take power and control over their life. Women's struggles for human rights have been more pronounced with regard to prevention of violence than to fulfilling their economic rights, but still the aftermaths of war and collective violence bear a heavy burden of their mental health.

The impact of women's multiple roles even in times of conflict may add to the stress in their lives and be linked to negative health outcomes, but multiple roles may also benefits to women's physical and mental health.

Awareness of the particular problems of women are faced with in situations of war should increase and therapeutic interventions should be established that may fulfill the particular needs of these women.

A comparison of Bosnian and Somali psychiatric patient who are refugees of their respective wars

J.D. Kinzie (*USA*)

In many ways, Bosnia and Somalia are similar. Both went through civil wars and ethnic cleansing in the early '90s and both are predominantly Muslim countries. Both have refugees who have come to the United States and are patients in our Intercultural Psychiatric Program.

This paper addresses the similarities and differences between these two groups following very traumatic war experiences.

Both groups suffer from Posttraumatic Stress Disorder and Major Depressive Disorder. There is also a great deal of irritability, which affects domestic relationships in both groups. However, there are major differences. The Bosnians have higher levels of education and about half have found employment in the U.S. The Somalis are very conservative Muslims and have low education (women often having none) and have a very low rate of employment in the United States. In addition, the ongoing war experiences and violence in Somalia has increased the awareness and symptom patterns of these patients.

The difference in symptoms and prognosis of their disorders, as well as social and psychiatric consequences of the wars are further discussed in this paper.

Psychiatrists and the subcultures of conflicts

M. Scarpinati Rosso (*Sweden*)

Conflicts exist at different levels in society. Psychiatrists are often requested or forced to play significant roles in conflicts. War is an extreame form of conflict - accompagnied by many conflicting subcultures.

Which are the professional means psychiatry can offer in conflict situations and how can a psychiatrist avoid the pitfalls and diffuculties generated by the confict?

The presentation will discuss the role of psychiatry in conflicts and the embedded ethical implications when a psychiatrist becomes involved in conflicting institutional powers.

Are ethical guidelines or ethical supervision required?

The impact of conflicts and wars on mental health services

H. Wahlberg (*Finland/Sweden*)

Violations of human rights wherever by oppression, persecution, prejudice, discrimination, imprisonment, violence, conflicts and war **impair mental health** and have negative consequences on work, social life, interpersonal relations, self-esteem and autonomy.

During the bitter ethnic cleansing and Wars in the Balkan 1991-2001 hundreds of thousands of people were killed and millions displaced - many as refugees in other countries.

The mental health services in the Region were grossly neglected during the Wars. The buildings fell into decay, basic necessities and resources for e.g. medicine, food and heating were curtailed and salaries, training and support of staff reduced. The services and the living conditions for the patients deteriorated, human rights were violated and the stigma of mental illnesses increased.

The conflicts lead also to abrupt closures of some of the mental health services. The population and the personnel had to flee from the approaching war and abandon the hospitals - with the doors open. The patients had to take care of themselves and find support among the population and the refugees.

During the time of the state of Yugoslavia patients were accepted to mental institutions all over the country. As a consequence of the Balkan war the region was divided ethnically into many countries. Some of the patients found themselves "in the wrong country" – their ethnic affiliation was different from the country were the hospital was located – but they could not be transferred.

The international community and its humanitarian organizations started at the end of the Balkan War programs to support vulnerable groups, among them the Mental Health Services' development programs coordinated by the World Health Organization. The programs managed to reform and modernize the mental health services and to improve the conditions for the patients.

Displaced and haunted by conflicts, suicide attempts in migrant. A cross-cultural perspective

G. Niklewski (*Germany*), R. Kneginja (*Germany*), L. Hartmut (*Germany*)

The Nuremburg Alliance against Depression evaluated during more than 5 years all suicide attempts in the catchment area of the city of Nuremberg (500.000 inhabitants).

A sub-analysis of the suicidal attempts among the migrants (20% of the population of Nuremburg) showed cultural specific background problems among the immigrants and that especially young Turkish women had cultural background problems and memories in the context of their suicide attempts.

Summary and conclusion

H. Wahlberg (*Finland/Sweden*)

Many refugees come from conflict and war conditions. The impact of conflicts and war varies and there are different subcultures in a war. Often wars strike vulnerable groups as women, children, disabled persons and people with mental problems with both immediate and long-term consequences. International humanitarian assistance and peace programs should support affected groups and not merely focus on the warfare parties. Demeaning routines and treatment that resemble war cultures should be abolished from asylum policy.

Psychiatrist working in conflict situations or with asylum seekers need information about the cultures of conflicts and wars.

Video Session (VS-2)

Saving face. Recognizing and managing the stigma of mental illness in Asian Americans

Chair: F. Lu (*USA*)

Educational Objectives

(1) To understand how Asian-American patients present their stigma of mental illness that is related to cultural and family issues

(2) To understand how skilled therapists manage stigma.

Description

This 20-minute video presentation will show one of three interviews on the 2008 DVD entitled "Saving Face: Recognizing and Managing the Stigma of Mental Illness in Asian Americans" followed by a brief discussion. The DVD consists of three simulated interviews between psychiatrists and actors who play the roles of simulated patients. The cases include: 1) a South Asian-American woman with bipolar disorder, 2) a Vietnamese-American man with somatic presentation of depression and PTSD, and 3) the parents of a Pilipino-American child with ADHD (this one will be shown). The interviews show how the stigma of mental illness manifests in Asian-American ethnic subgroups in the individual, family, and community as well as how psychiatrists manage the stigma. Elizabeth Kramer and Francis Lu, co-directors. 58 minutes. Distributed at cost by the Mental Health Association in California. For further information about the DVD, with facilitator's guide, see http://www.mhac.org/barriers/antistigma.cfm.

Financial Disclosure

Francis Lu has no financial disclosures in connection with the DVD. He is the copyright owner.

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Standard Symposium (SS-VII-33)

Migratory Policies and Services Organizations Facing Stress and Pathologies in Refugees and Immigrants

Chair: J.M. Havenaar (*The Netherlands*); Cochair: A.D. MacLeod (*UK*)

Depression or demoralization among refugees attending mental health services

A.D. MacLeod (*UK*)

Rationale

Antidepressant medications are often of limited therapeutic benefit in 'depressed' and anxious refugee patients. Applying Western diagnostic conceptualisations of affective, anxiety and post traumatic states often proves unsatisfactory. This may be an explanation for the poor medication responsiveness.

Method

An audit of 64 patients seen in a Refugee and Migrant Clinic revealed that ' low mood' was the predominant presenting psychiatric symptom. Major Depressive Episode (DSM IV) was diagnosed in 47%, dysthymia in 20%, and Adjustment Disorder with depressed mood in 5%. PTSD (excluding Partial PTSD) was diagnosed in 12%. Trials of antidepressant medications were conducted for 71% of this cohort.

Findings

Only 36% of those trialled on medications had clinically good response rates. Non compliance was a likely influence for some, however the poor response rates also raise queries regarding the applicability of DSM IV Mood Disorders in this mainly African and Middle Eastern refugee clinical sample.

Conclusions

Demoralisation may be a useful conceptualisation of the negative emotional distress of those from non-Western countries struggling to acculturate in new countries of settlement. Psychotherapeutic interventions may be more appropriate than ineffective psychotropic medications, with potential for adverse reactions. A further study differentiating major depression and demoralisation has been commenced.

The cultural formulation of a political refugee. A case report

F. Ceccon (*Italy*), C. Callegari (*Italy*), M. Diurni (*Italy*), R. Bressani (*Italy*), M. Mattia (*Switzerland/Italy*), S. Vender (*Italy*)

We report a 34-year-old man, born in Sierra Leone. He came to Italy in 2000 as a political refugee. The young man emigrated after the outbreak of a civil war that torn Sierra Leone for over 10 years (between 1991 and 2002) and whose impact on the living conditions of the population was devastating.

The patient is known to the psychiatric services of UOP 2 of Varese (Italy) since 2007, when he was hospitalised in the psychiatric department of Ospedale di Circolo and Fondazione Macchi for psychotic disorder. From November 2008 to date he is a guest at the CRM (Middle assistance Community for Rehabilitation) in Varese for a rehabilitation project.

The layout of the cultural development of a clinic case is used. Our attention focused on the cultural identity, on the cultural explanation of the disease and on psychosocial aspects. The relationship between the clinician and the patient is read in a cultural perspective. We arrive at the

overall assessment for diagnosis and treatment based on a bio-psycho-socio-spiritual model.

First contact incidence of schizophrenia among native Dutch and Moroccan immigrants in the The Netherlands. A cross-cultural perspective

J.M. Havenaar (*The Netherlands*)

Background

Several studies have reported increased incidence rates of psychotic disorders among immigrant groups (Cantor-Graae & Selten, 2005). In particular, substantially increased incidence rates have been reported among Moroccan immigrants to the Netherlands (Selten et al., 2001). Surprisingly, the cross-cultural validity of the diagnostic instruments used in these studies used was never tested. In an earlier study in Casablanca, Morocco, we have found indications that a standardized diagnostic instrument such as the Comprehensive Assessment of Symptoms and History (CASH; Andreasen et al., 1992) may lead to over-diagnosis of psychotic disorder among Moroccan patients, in comparison to the diagnostic ratings of native Moroccan psychiatrists. A modified, cultural sensitive version of the CASH (CASH-CS), however, showed good agreement with these ratings (Zandi et al., 2008).

Aims

The aim of this study was to examine whether the incidence rates of schizophrenia among Moroccan immigrants to the Netherlands remain increased when a cultural sensitive diagnostic interview is used.

Method

We compared first contact incidence rates based on the standard CASH with those based on the cultural sensitive version of this instrument (CASH-CS).

Results

As in earlier reports, the age and gender adjusted relative risk for schizophrenia among Moroccans compared to native Dutch was significantly increased, if they were based on the standard version of CASH (OR 7.8; 95% CI 4.0-15.2). However based on the culturally sensitive version of the instrument, CASH-CS, the difference in the incidence of schizophrenia was no longer statistically significant (OR 1.5; 95% CI 0.5-4.3). Most of the cases in which the diagnosis of schizophrenia was not confirmed by the CASH-CS, were reclassified as psychotic or non-psychotic depressive disorders, based on the cultural sensitive version of the instrument.

Conclusion

The increased incidence of schizophrenia among Moroccan immigrants in the Netherlands which has been reported by several authors (Selten et al., 2001) may at least in part be explained by cultural bias in the diagnostic assessment. This finding has important consequences for the subsequent treatment and prognosis of these patients. However, because there is no diagnostic gold standard in psychiatry, future follow-up studies will have to determine whether patients who were reclassified as not having schizophrenia, have indeed a better prognosis.

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A university based mental health clinic for the immigrant and refugee communities in Oregon

P.K. Leung (*USA*)

The Intercultural Psychiatric Program (IPP) of Oregon Health & Science University (OHSU) was established in 1977 at the height of the influx of refugees from Indochina to the United States. Over the past 32 years IPP has expanded its focus groups beyond those from Vietnam, Laos and Cambodia to include immigrant and refugee from other parts of the world. IPP is now serving people of more than 18 language groups. The clinic utilizes an ethnic-clinician-based model to provide cares rather than relying on interpreter to help bridging the cultural and language gaps.

Although IPP has always been an integrated part of an academic department of a medical university it remains true to its original mission to provide sound clinical cares to the immigrant and refugee clienteles in the state of Oregon. IPP is recognized by the state and county authorities as a mental health organization (MHO), eligible for Medicaid & Medicare funding to provide comprehensive mental health services in the community. IPP currently serves more than 1,400 patients with a variety of psychiatric diagnosis. Our patients have high percentage of major depression, PTSD, other anxiety disorders & psychotic disorders. The psychiatrists at IPP also manage medical conditions of less complexity.

As an integrated part of the medical university the psychiatrists and clinicians of IPP have fully participated in teaching and research activities. Every year IPP has a senior psychiatric resident on rotation and closely supervised by a faculty psychiatrist of the program. In addition, medical students and other allied health professionals and students would come to the program opting for clinical experiences in a cross-cultural mental health setting. IPP also have active clinical research activities through its Oregon Trauma Treatment Center (OTTC), a federal funded program. Over the years the faculty psychiatrists group has published more than 100 professional articles and book chapters aiming at advancing the field of cross-cultural psychiatry.

In the midst of global financial crisis IPP is not immune from it's sever effect. For the past couple of years in particular the last 6 months IPP has faced impact from different fronts. Our mother organization, the university has increased its demand in the form of overhead cost allocation that cannot be met unless deep reduction in personnel be made. The decrease of public funding due to budgetary reduction by the state will mean significant cut of revenue in the foreseeable future. All these are challenges in seriousness that the program had never faced before and may threaten the health of its existence.

Standard Symposium (SS-VII-34)
Doctor- Patient Communication

Chair: E. Koch (*Germany*); Cochair: M. Schouler-Ocak (*Germany/Turkey*)

The change of doctor-patient relationship in general and under transcultural aspects

E. Koch (*Germany*)

The doctor-patient communication involving an exchange of information about diagnosis and treatment are a very crucial part of the medical practice. The success of this communication depends not only on the medical knowledge of the doctor, but at the same time on his communication skills. The establishment of an appropriate and effective communication between doctors and patients is now considered as a basic human right.

Psychiatry is a field where the dimensions of communication and interaction are of great significance. However, the contemporary norms concerning the doctor-patient relation bear some specific problems within psychiatric practice. To begin with, the concept of informed consent becomes problematic in relation to certain patients who are not able to take their own decisions.

A fundamental principle of the social psychiatric tradition is to provide the patients with greater rights and responsibilities for participation. However, this tradition has been declining in the past twenty years and biological psychiatry is on the rise. The inherent danger of the biological approach is the tendency to generalize research results and use them as the fundamentals of treatment, thereby marginalizing the individual characteristics and the subjective world of the patient.

Despite these contemporary developments, psychiatrists should strive to realize a pattern of doctor-patient relationship which is both sensitive to the requirements of this field and as democratic as possible. These considerations are even more difficult for the therapeutic relationship to patients with migrational background.

Non-medical help seeking behavoiour in Turkish psychiatric patients

E. Mutlu (*Germany/Turkey*)

Non-medical or extra-medical help seeking behaviour has been regarded as a complicated social concept based on ancient and fundamental psychological needs and has been evaluated from certain perspectives of social sciences.

Cultural and religious attitudes, common health beliefs and perception about mental disorders are suggested to be the major grounds for the inclination of seeking non-professional help for mental disorders. A review of the literature and a preliminary study about non-medical help seeking among Turkish psychiatric patients from Istanbul (Bakirköy State Hospital for Mental Disorders) will be presented in this presentation.

Cultural epidemiology of neurathenia spectrum disorders in four urban general hospital outpatient clinics in Pune, India

V. Paralikar (*India*)

Disorders emphasizing symptoms of medically unexplained fatigue and/or weakness, collectively termed Neurasthenia Spectrum Disorders (NSDs), typically emphasize a biological basis in the West and social origins in East Asia. Diversity of both patients' explanatory models (EMs) and professional formulations, and absence of biological diagnostic tests help to explain why NSDs are not included among DSM-IV diagnostic categories. Subjective illness experience, perceived causes, and help-seeking also vary not only across but also within cultures. We aimed to elucidate this cultural epidemiology of NSDs by examining the EMs of patients from four clinics with distinct cultural orientations. We studied 352 outpatients with EMIC interviews in Psychiatry, Medicine, Dermatology, and Ayurved clinics of an urban hospital. Cross-clinic and cross-cultural comparisons of categories and narratives of illness experience and meaning indicated cross-cutting and distinctive features. EMs were diverse. Biological factors were more prominent for men and psychological factors more for women. EMs of NSDs highlighted social distress, 'tensions,' physical, psychological, and cultural ideas generally and for each clinic. Biological explanations were most prominent in the Medicine clinic, psychological factors in Psychiatry, and cultural factors in Dermatology. Ayurved patients de-emphasized the psychological component in their EMs. Social causes were equally prominent in all four clinics. Pluralistic help-seeking was most common among patients from Psychiatry and least in Medicine. Various forms of self-help, though tried by the majority, could be elicited only in response to probe-questions. Findings indicated their clinical relevance, social contexts and cultural meaning. Clinical formulations sensitive to cultural meanings enable culturally appropriate counselling.

Explanatory models and the semantic concepts regarding expectation and treatment of patients suffering from somatoform disorder. A transcultural comparison

M. Schouler-Ocak (*Germany/Turkey*)

In current professional medical care a biospychosocial model for the etiology of somatoform disorders is held by practitioners and conveyed to patients – however this seems to be most often rejected by patients in their initial contact with psychiatric services. To bridge the gaps between professional caregivers´ and patients´ notions, the subjective views of the patients regarding their illness is explored.

The planned study is to provide culturally specific as well as transculturally valid aspects of the subjective illness perspective. Illness behaviour – from the interpretation of symptoms as well as helpseeking to the evaluation of treatment - is learned and thus mediated through cultural norms and values.

The comparison of the semantic concepts of German patients and patients with a background of migration from Turkey suffering from somatoform disorders should lead to implications for the development of culture sensitive concepts facilitating effective therapeutic intervention in daily practice.

Standard Symposium (SS-VII-35)
Culture, Humor and Psychiatry – Part 2

Chair Chair: J. Obiols-Llandrich (*Andorra*); Cochair: R. Wintrob (*USA*)

American Culture, Humor & Psychiatry

J.D. Kinzie (*USA*)

The 1971 article by Lawrence Kubie on the destructive aspects of humor psychotherapy was a reflection of the times. Psychiatry and psychotherapy was considered serious, dull and humorless. Since that time there have been many changes and, although humor can be considered defensive and hostile, it can be extremely useful in therapy and can keep the tension low. With humor, a certain therapeutic atmosphere is created which includes both assertiveness and compassion. The atmosphere lets the patient know the therapeutic limitations but, at the same time, allows him/her to take risks and learn more about who he/she is (Salameh 1993).

From a diagnostic point of view, we know that humor appreciation is deficient in schizophrenia (Bozikas et al 2007). Older people have difficulty with humor comprehension, related to cognitive decline (Mak & Carpenter 2007). Jokes differ by country and ethnic group – e.g. Americans and Canadians prefer jokes with a strong sense of superiority (BBC News 2002). This type of humor also seems to be present among (and about) psychiatrists. The psychiatrist's own pathology may lead to difficulties in treatment, which is often the subject of psychiatrist jokes.

Humor can be used as a criterion for gaining health. The establishment or return of a positive sense of humor may well be considered a goal or at least a highly desirable by-product of psychotherapy and the degree to which the sense of humor becomes established may be considered the one criterion in the success of therapy (Olson 1976).

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South African humor and mental health

D. Mkize (*South Africa*)

Humour is defined as the tendency of particular cognitive experiences to provoke laughter. People of all ages and cultures respond to humour. The extent to which an individual will find something humorous depends on a host of variables one of which is culture or cultural background.

South Africa has gone through two major catastrophies; these being Apartheid and HIV/AIDS. For their mental well-being, South Africans have developed a sense of humour that protects them; either as individuals or as a collective from developing psychiatric disorders.

These humorous stories will be narrated at this symposium depicting the protective power of humour to maintain mental health or well-being.

Culture, humor and psychiatry. A synthesis in African culture

S. Okpaku (*USA/Nigeria*)

African homour derives from the socio-philosophical and religious context of African culture. Humour is an integral part of African life, mythology and folklore. The humour in African oral tradition passed seamlessly onto written African literature. The birth in the 1930s of the literary philosophy of negritude, upholding pride in African heritage and identity, spurred the rise of indigenous written African literature which served to counter the western literature that was the bulk of reading material in Africa. Most famous of the new authors was Amos Tutuola, a semi-literate novelist whose The Palmwine Drinkard, with free-wheeling imagination and humour Dylan Thomas described as being reminiscent of the origin of the English language.

The "Onitsha market Novels", named after a famous marketplace in Nigeria, where these novellas were widely available, were part of this genre.

More formal contemporary African authors like Cyprian Ekwensi, Chinua Achebe and Nobel laureate, Wole Soyinka, have used humour and satire to handle the political challenges of colonialism and independence. The advent of radio (and subsequently television), caused the proliferation of satirists and humorists doing both drama and stand-up comedy in English, French, patois and local languages.

The extension of African humour into the African Diaspora has been credited with sustaining the mental health of African-Americans through the horrific experience of slavery and its aftermath of segregation and discrimination. The presentation will cover this evolution, and conclude with an analysis of the use of humour as a supportive expressive therapy in the America experience.

Catalan culture, humor and psychiatry

J. Obiols-Llandrich (*Andorra*)

Each culture develops its own sense of humor. So, Catalan type of humor might have specific traits. A humorous glimpse on Catalan culture will be presented.

Besides, there are probably many unsuspected links between humor and psychiatry. A few of them will be reviewed in this presentation.

1. To begin with, if we consider linguistic jokes, some of the mechanisms that explain how humor works, might be similar to linguistic disturbances shown by some psychotic patients (mostly bipolar or schizophrenic patients).
2. People like to make fun of psychiatrists. Some examples will be analyzed as well as the possible reasons of this fact.
3. Freud himself developed some interesting ideas on the mechanisms of jokes. Laughter therapy seems to attract an increasing interest. At the same time, most psychiatric patients do not seem very inclined to appreciate the sense of humor.

Standard Symposium (SS-VIII-36)

At the Frontiers of Cultural Neuroscience

Chair: J.Y. Chiao (*USA*); Cochair: L. Stuppia (*Italy*)

Neuroplasticity, Cultural Evolution and Cultural Difference [videoconferencing]

B. Wexler (*USA*)

The structure and function of our brains is shaped by environmental input to a much greater degree and for a much longer time after birth than are the brains of other animals. Moreover, we humans shape the environment that shapes our brains to an extent without precedent. These two things together give us great adaptability as a species, make possible rapid and accelerating changes in society and technology, and create differences in mind and brain function in people raised in different cultural environments. On the individual level, this environmental shaping of the structure and function of the developing brain creates a homology between peoples' brains and the major recurring features of their environments.

Once, we are young adults, however, our neuro-psychological structures are established and self-sustaining, the neurochemical processes that support formation of new connections among nerve cells are much reduced, and we act on the world largely to make our external reality match the established internal structures. Mechanisms for maintaining the fit between internal and external include affiliating with like-minded people, lower perceptual thresholds for things that are familiar, and forgetting and discrediting information that does not fit with past experience and internal structures. There are times, however, when the world changes beyond the ability of these mechanisms to maintain the fit between internal and external. On the individual level these include bereavement, immigration and intergenerational conflict. On the social level these include the meeting of cultures which is associated with violent conflict as people fight to control the cultural environments important to their neurobiological well-being. Understanding this "neurobiological antagonism to difference" is of great importance as we attempt to deal with the pressures of globalization and the inter-ethnic conflicts that surround us today.

Gene X culture interaction. The effect of culture, serotonin receptor polymorphism (5-HTR1A), and oxytocin receptor polymorphism (OXTR) on social support use

H. Kim (*USA*), D. Sherman (*USA*), J. Sasaki (*USA*)

We examined the influence of genetic and sociocultural factors on one's stress reactivity and coping style. Research has shown that people from different cultures cope differently in stressful situations. People from Asian cultural contexts tend to rely on social support that does not involve disclosure, but people from European American cultural contexts tend to seek social support with explicit disclosure. We examined how genes are also involved in stress coping by interacting with culture. The C-1019G single nucleotide polymorphism (SNP) in 5HTR1A, a serotonin receptor gene, has been linked to stress reactivity, and in particular, G allele for serotonin receptor gene is associated with depression and anxiety. The rs53576 SNP in OXTR, oxytocin receptor gene, has been linked to the tendency for social affiliation, and in particular, G allele for OXTR is

linked to prosocial behavior, more sensitive parenting. Therefore we assessed these polymorphisms in European Americans and Koreans in relation to social support use to cope with stress. Saliva or cheek swab samples were collected from participants and DNA was extracted using the Puregene kit (Qiagen). The 5HTR1A genotype (CC, CG, GG) and OXTR genotype (AA, GA, GG) were assessed using real time PCR at Tufts University. Each subject also completed a series of questionnaires that measure the level of hostility in family environment, psychological distress, and individual differences in stress coping. Results show the gene by environment interaction with 5-HTR1A, which is one of the first demonstrations of this interaction with this particular polymorphism. Individuals with the G/G genotype showed a greater association between the degree of environmental risk and psychological distress, compared to individuals with the C/G genotype, who in turn showed a greater association than individuals with the C/C genotype. Given this finding, we examined the roles of culture and OXTR in influencing the use of social support. We found that European Americans with the G/G genotype of OXTR reported seeking greater social support as a function of distress experienced, compared to the G/A or A/A genotypes. By contrast, Koreans with the G/G genotype did not seek social support as a function of stress any more than those with the other genotypes, as it is not the culturally normative way in which people cope with their stress and affiliate with close others.

In summary, we obtained a gene X culture interaction in social support use (see also Kim et al., in press for the gene X culture interaction on modes of attention). It appears that those who are more genetically affiliation-prone seek social support more, but only when it is a culturally sanctioned way of coping (Kim et al., 2009).

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Culture and neural basis of ingroup bias in empathy

B.K. Cheon (*USA*), D. Im (*Korea*), T. Harada (*USA*), V.A. Mathur (*USA*), J. Scimeca (*USA*), H.W. Park (*Korea*), J.Y. Chiao (*USA/Korea*)

Empathy refers to the capacity to understand and experience the emotional states of others. Recent evidence indicates that neural activity during empathy may be modulated by group membership of the target, as well as the degree to which one values social hierarchy. Preference for social hierarchy also varies substantially across cultures, suggesting that the neural correlates of empathy may be modulated by cultural variations in preferences regarding social hierarchies.

Here we investigated neural processes underlying ingroup biases in empathy among native Korean and Caucasian-American participants using cross-cultural functional magnetic resonance imaging at 3T. During scanning, participants viewed complex visual scenes of Korean and Caucasian-American targets in either emotionally painful or neutral situations and indicated their empathy towards targets. Together, members of both cultures activated regions associated with cognitive processes underlying empathy, such as the medial prefrontal cortex and the bilateral temporo-parietal junction (TPJ) when viewing ingroup relative to outgroup members in pain. Comparing between groups, the Korean participants exhibited greater activity in the left TPJ than Caucasian-American participants when viewing ingroup relative to outgroup members in pain. Furthermore, the relationship between cultural variation in social hierarchy preference and endorsed ingroup biases in empathy was mediated by cultural variation in the recruitment of the left TPJ during ingroup bias in empathy.

The current study suggests that cognitive processes underlying empathy, such as reasoning about emotions and mental states of others, may be an important mechanism through which social hierarchy preference is translated into ingroup empathy biases.

Culture-Gene coevolution of individualism-collettivism and the serotonin transporter gene

J.Y. Chiao (*USA*)

Culture–gene coevolutionary theory posits that cultural values have evolved, are adaptive and influence the social and physical environments under which genetic selection operates. Here, we examined the association between cultural values of individualism–collectivism and allelic frequency of the serotonin transporter functional polymorphism (5-HTTLPR) as well as the role this culture–gene association may play in explaining global variability in prevalence of pathogens and affective disorders. We found evidence that collectivistic cultures were significantly more likely to comprise individuals carrying the short (S) allele of the 5-HTTLPR across 29 nations.

Results further show that historical pathogen prevalence predicts cultural variability in individualism collectivism owing to genetic selection of the S allele. Additionally, cultural values and frequency of S allele arriers negatively predict global prevalence of anxiety and mood disorder. Finally, mediation analyses further indicate that increased frequency of S allele carriers predicted decreased anxiety and mood disorder prevalence owing to increased collectivistic cultural values. Taken together, our findings suggest culture–gene coevolution between allelic frequency of 5-HTTLPR and cultural values of individualism–collectivism and support the notion that cultural values buffer genetically susceptible populations from increased prevalence of affective disorders. Implications of the current findings for understanding culture–gene coevolution of human brain and behaviour as well as how this coevolutionary process may contribute to global variation in pathogen prevalence and epidemiology of affective disorders, such as anxiety and depression, are discussed.

Standard Symposium (SS-VIII-37)

Cinema, Psychiatry and Mental Health. South Asian Perspectives

Chair: M.G. Weiss (*Switzerland*); Cochair: M. Agashe (*India*)

Cinema, psychiatry and mental health. South Asian perspectives

M.G. Weiss (*Switzerland*)

Psychiatrists, sociologists, the lay public, artists and filmmakers all have their own ideas about what constitutes a satisfactory explanation for suicide and suicidal behaviour. As a practical matter, mental health professionals typically focus on the role of high-risk disorders, and public health practitioners may focus on media accounts and efforts to limit the means for deliberate self-harm through gun control, pesticide policy and other interventions. But popular accounts of suicide, reflected in newspapers, literature, and films, are more likely to explain suicide with reference to life events, underlying problems and triggers of suicidal behaviour.

Many Indian popular and art films in Hindi and various regional languages refer to suicide either as a way to underscore the intensity of emotional suffering or as a more integral feature of the plot. Analysis of such films yields a framework for explaining the cultural contexts of underlying problems and triggers. The framework emerging from that analysis clarifies cultural values concerning life, death, and suffering, and highlights issues of broader interest for mental health beyond suicide prevention. Characteristic themes refer to questions of gender, livelihood, oppression and dignity. Plots include frustrated romance, intolerable marriages, intergenerational conflicts, unachievable ideals and unmet responsibilities, victimization and humiliation of women, financial ruin and dishonour of men, insurmountable social forces (e.g. communal conflict and globalisation), irreconcilable grief and loss, and calculated sacrifice for secondary gain or to achieve explicit political or spiritual aims. Illustrated with examples from selected films, this analysis clarifies the role of cultural values, the benefits and limitations of psychiatric treatment to prevent suicide, and the value of developing awareness through entertainment to promote mental health.

Portrayal of traditional healing with film. An experience from India

A. Pakaslahti (*Finland*)

Indian cultural riches include many healing traditions. They provide help for mental health problems to large segments of population that usually remain unknown to government mental health system. Inasmuch as community-based psychiatric services are scarce, it is worthwhile to document and better understand such cultural resources.

Documentary films offer prospects for increasing awareness and educating the public, social scientists and health professionals. Some Indian television programs have recently made use of such documentaries, with both positive and problematic results. Adequate documentary portrayals of traditional healing for mental health problems should be based on relevant scientific research that is conducted with appropriate methods, supported by necessary technical resources, high-quality camera work, artistic direction and adequate editing facilities.

This presentation reviews experience gained from one such effort. The film "Kusum" portrays prospectively the treatment of a depressed Hindu girl and her family by a traditional healer. The film was rooted in ongoing transcultural psychiatric research of networks of North-Indian healers. Findings focused attention on pluralism in help seeking, multiplicity of local voices, structure and content of treatment, follow-up and efficacy.

The film has been used for educational purposes in teaching settings. The relationship between scientific and artistic values in documentary film making is a creative interaction. The implications of experience making this film and its generalisability are discussed.

Feature films for teaching cultural psychiatry

S.R. Parkar (*India*)

Cinema integrates worlds of fantasy and reality to entertain and instruct, and sometimes to help us think, communicate and assist others. Films are particularly interesting for mental health when they examine the nature of psychiatric illness and mental health problems, and when they portray the experience, meaning and resolution of these problems. Whether a portrayal of mental illness is simplistic and misleading, or sensitive and informative, films remain a matter of professional interest because they both represent and in turn influence popular ideas about mental illness and psychiatry.

Based on experience in an academic psychiatry training programme in Mumbai, this presentation considers the value of referring to well-known Indian films in psychiatric training through their representation of cultural features of relevant mental health issues. Because romance, family interactions, social relations and the impact of adverse circumstances are frequently topics of many feature films, both in popular commercial and artistic productions, they may be useful in demonstrating the interplay of gender and mental health problems, and the cultural variation of psychopathology, stressors and support. Examples are drawn from recent films concerned with suicidal behaviour, multiple personality disorder, and other psychiatric disorders.

Because of widespread interest in Indian films in Mumbai and throughout the country, cinema may facilitate communication both between mental health professionals and patients, and also among professionals. Even for films that are simplistic and misleading, which are qualities detrimental to public awareness, elaborating how that is so may be a useful exercise for mental health professionals, helping them to identify and address popular misperceptions. Inasmuch as South Asian films are constructed with consideration of cultural values that are recognizable, if not shared, by Indian audiences, experience in training shows how it may be engaging and effective to embed culturally significant clinical communications in apt references to illustrative films.

Schizophrenia in Indian cinema

M. Agashe (*India*)

Cinematic portrayals of mental illness typically straddle interests of presenting painful emotional experience, which may be painful to witness, and creative efforts to engage an audience.

Although early attempts to present schizophrenia in Indian films sacrificed authenticity by pandering to popular notions of entertainment, several recent productions portray the character with concern and authenticity, so as to promote awareness and suggest the value of treatment and support.

Three recent Indian feature films in which the lead character is a person living with schizophrenia – 15 Park Avenue, Devrai (Sacred Grove), and 'Mazhi Gosht (My Story)' – each

examine the impact of the disorder on the affected person and on his or her family, and they indicate culturally embedded ways that psychiatry aims to help. Each film prioritizes somewhat differently values of entertainment and efforts to stimulate serious thinking about schizophrenia in the viewing audience, practical concerns about the importance of early recognition, and the value of treatment. They also indicate different approaches to negotiating the tensions between entertainment, dramatic license, and authenticity. To a different extent, each accepts responsibility for their cinematic portrayal of a serious problem affecting many people, which both art and cinema may too often distort or ignore. Efforts of mental health professionals benefit from an appreciation of how such media representations of mental illness, both simplistic and authentic, affect popular culture and both the nature and response to mental illness.

Standard Symposium (SS-VIII-38)

Influence of the Law and Culture on Psychiatric Practice. Patients' Rights and Psychiatrists' Responsabilities

Chair: L. Ravin (*USA*); Cochair: A. Eligi (*Italy*)

Experiences and expectations of non-western patients in a dutch forensic psychiatric hospital

F. Kortmann (*The Netherlands*)

Rationale

Forensic psychiatric services are not serving the multi-ethnic societies in Western countries as they should. What are cultural related bottle-necks which non-western mentally disordered offenders experience in mandatory treatment in a Dutch forensic psychiatric hospital?

Method

Semi-structured in depth interviews were held in four forensic hospitals with 12 first and second generation non-western patients from the largest ethnic groups in The Netherlands (Turkish, Moroccan, Curacao, Suriname). For comparison, 8 native Dutch patients and 7 staff members were interviewed. Issues addressed in the interviews were (1) verbal and non-verbal communication, (2) cultural customs and habits, (3) illness presentation, explanations and diagnosis, (4) individualism versus collectivism, (5) taboos, (6) interaction between male patients and female staff, (7) differences in age, (8) knowledge of and interest in cultural background of patients, (9) cultural background of staff, (10) discrimination and (11) hospital organization.

Main findings

Analysis of the interviews revealed that non-western patients encounter major difficulties in verbal and non-verbal communication. They feel that they don't know how to express themselves in the language of the staff. The legal reports of the staff about them often don't correspond with that what was meant by patient to express. Interpretations of staff are not recognisable for the patient and witness stereotyping and generalizations. Some patients have difficulties to express emotions, which is interpreted as unfeeling, and therefore as psychopathic. Some patients mentioned that they are used to avoid looking in the eyes of a professional, as a signs of respect. The professional interpreted this behaviour as lack of interest, and motivated him to intensify his discourse. Sometimes the staff get confused by vivid gesticulations of non-western patients; it provokes anxiety and fear in them. Some non-western patients put strong emphasis on personal hygiene.

They want to wash hands before eating, also in isolation room and they don't want to accept pills which are touched by staff. This is sometimes is interpreted by staff as pathological fear for contamination or even a delusion. Non-western patients sometimes tend to show more overtly their good habits, qualities and capacities than western patients. This is sometimes interpreted as symptom of narcissism. The relationship with the family is very important for many non-western patients. On the contrary, western staff tend to promote to loosen the ties with the family, because the patient has to take his own responsibility.

Some non-western patients have great difficulties with revealing their criminal past in groups-sessions to other patients and staff they don't know. Sometimes non-western patients don't feel respected by the staff, especially if they are quite older that the latter. They think that younger staff, especially the females, does not have enough experience of life. On the other hand, female staff experience that older male patients sometimes behave denigratory or pedantic towards them.

Conclusions

The awareness of cultural differences and its consequences for treatment is greatly underestimated and neglected in Dutch forensic psychiatric hospitals. This lack of awareness is greatly disadvantageous for non-western patients. It may lengthen their mandatory stay in the hospital. This issue becomes even more urgent, since the number of non-western patient in forensic psychiatry is increasing. Education,

training and supervision in cross-cultural issues should get a prominent position in the management of the hospital.

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Cultural and legal implications of religion in psychiatry. A case report

A. Eligi (*Italy*)

Davide is a 25 years old, Italian and Catholic young man. He has been an inpatient in a therapeutic and rehabilitation housing facilty (CTR) for psychotic disorders for 3 years. The permanence of Davide was determined by verdict of the judge and made obligatory. In fact, six years ago, Military Court tried him for grievous bodily harm and attempted murder. A brief psychotic disorder was diagnosed and Davide was declared unfit to plead and committed to the Psychiatric Penitentiary Hospital (OPG in Italian). After 3 years, because of Davide's good conduct and early symptoms' improvement, the military judge decided to move him from the OPG to the CTR. During the last three months he has been meeting a priest, a well-known exorcist. These weekly sessions with the priest often take place privately in Davide's room. The psychiatrist looking after Davide doesn't know if the meetings are just a sort of spiritual support and he fears a negative influence on Davide's mental health. Davide's case gives the opportunity to approach Legal, institutional and cultural aspects that links psychiatry with Catholicism in Italy.

Psychiatric advance directives, influence of North America culture on patient rights in receiving psychiatric care

L. Ravin (*USA*)

On November 5, 1990, the U.S. Congress passed the Patient Self-Determination Act (PSDA). It became effective on December 1, 1991. The PSDA requires that many Medicare and Medicaid providers (hospitals, nursing homes, hospice programs, home health agencies, and HMO's) give adult individuals, at the time of inpatient admission or enrollment, certain information about their rights under state laws governing advance directives, including: (1) the right to participate in and direct their own health care decisions; (2) the right to accept or refuse medical or surgical treatment; (3) the right to prepare an advance directive; (4) information on the provider's policies that govern the utilization of these rights. Since enacting the PSDA, Advance Directives have become an important legal tool that gives patients a greater voice in their mental health treatment. At least one half of the states in the USA adopted various forms of laws allowing patients, when competent, to appoint proxy decision makers (i.e. "Power of Attorney") and/or to make choices about particular treatments (i.e. "Advance instructions"), all to take effect should patients later become incompetent to make decisions for themselves.

However, this tool remains underutilized with caution expressed both by mental health professionals and mental health patients. Many psychiatrists are concerned that Advance Directives could be used by psychiatric patients to refuse any and all treatment modalities of psychiatric care, allowing them to remain unmedicated and "warehoused" in locked psychiatric facilities for lengthy periods of time. Awareness of such unintended consequences of Psychiatric Advance Directives was heightened after a patient in Vermont State Hospital successfully refused any and all psychotropic medications during her inpatient admission. The

Church of Scientology has also been advocating utilization of Psychiatric Advance Directives to refuse psychiatric care.

Research demonstrated that adult patients diagnosed with chronic and severe psychiatric conditions (such as schizophrenia, schizoaffective disorder, or major mood disorder with psychotic features) when given the opportunity, make reasonable treatment requests, directing their treatment team to current and appropriate regimens. Completed Psychiatric Advance Directives may facilitate treatment consent and collaboration, expedite the provision of clinical care, and avert hospitalizations. Data also suggest that people with mental illnesses are increasingly well informed about evidence-based cost-efficient interventions consistent with standards of care.

Different states in the USA enacted their own versions of Psychiatric Advance Directives describing patients' rights in outlining medical and non-medical care, physicians' responsibilities, liabilities and liability protections in respect to utilizing Advance Directives in psychiatric treatment. Some states chose to incorporate Psychiatric Advance Directives clauses into the statutes regulating use of Advance Directives for general health care.

Further research data, current laws' analysis, and legal challenges to existing laws should provide more in-depth appreciation of a patient role in participating and directing their own mental health care. To date, most of research in the field of Psychiatric Advance Directives has been done in North America, Western Europe, Australia, Japan and Singapore. However, as contemporary medicine across the globe steps back from the paternalistic approach in delivering health care, it is foreseeable to observe Psychiatric Advance Directives Laws emerging in other countries.

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Note

Mental health declaration and power of attorney act analysis developed for the Pennsylvania Psychiatric Society by Robert Hoffman of the Harrisburg Office of Wolf Block Schorr and Solis-Cohen, LLP, with the assistance of PPS Executive Director Gwen Lehman

Standard Symposium (SS-VIII-39)
Culture, Aging and Mental Health
Chair: D. Chen (*USA*); CoChair: M. Kastrup (*Denmark*)

Organizational challenges in delivering mental health and successful aging in a culturally diverse community
A. Maffia (*USA*)

Flushing Hospital Medical Centre is a 320 Community Hospital that services the borough of Queens which is one of the five borough comprising New York City. Of all the boroughs in the city, Queens is by far the most diverse in the city and one of the most diverse areas in all the United States. As a result, the issues of culturally divers care from both the medical and the psychiatric perspective has become a huge issue in the care of the population of the area. Flushing hospital has recognized this situation and has devoted much time energy and resources addressing the care of the culturally diverse population that is ours. In 2008 the FHMC Department of Ambulatory Care and the Department of Psychiatry collaborated on a project to provide both Primary Care and Mental Health Services in the Primary Care clinic settings for all patients but especially for the Geriatric population.

Discussed in the presentation will be the organizational challenges that were encountered in the development and implementation of the plan. These organizational challenges also included issues regarding "buy in" by the executive administration and the various chairpersons. Also to be considered is the lines of authority and responsibilities among different disciplines involved.

Training of the staff becomes of paramount importance in this process. Primary care staff must be trained in both the necessary elements of introductory features of Psychiatric Interviewing techniques but also must integrate those techniques into a process that adequately addresses the cultural diversity of the population served. At the same time, staff must be added that is reflective of the diversity of the culture served. From the mental health perspective, an understanding of the cultural concerns and issues regarding mental health intervention needs to be integrated into the learning process of those treating professionals involved so that they can effectively intervene in the patient's life. Some of the mental health treating techniques utilized by the staff can be developed in such a way that they can be used with various cultures with similar results.

These programs will assist with enhancing finances by cutting costs to the institution by keeping patients healthier and not being admitted to the hospital. It will also cut down on ED visits and additional clinic visits. Most importantly, it will assist patients in utilizing the mental health services available because of the de-stigmatization process that takes place in the culturally sensitive clinics environment.

Multidisciplinary challenges in elivering mental health and successful aging in a culturally diverse community
R.S. Crupi (*USA*)

Purpose

The delivery of mental health care under normal circumstances necessitates effective collaboration between multiple disciplines. Physical health and mental health integration for successful aging, especially when serving a culturally diverse community, poses special challenges for multidisciplinary collaboration because it requires both cultural competency and untraditional partnerships among health care providers involving them in ever more complex interactions between themselves and their patients.

Materials and Methods

The Flushing Hospital Medical Center (FHMC) is a 325-bed community hospital in Flushing, New York, located in New York City's Borough of Queens. The hospital's service area comprises one of the most culturally diverse communities in New York City. In January 2008, the FHMC Ambulatory Care Department began a project to integrate mental health and physical health services for elderly patients (> 65 years) in the Adult Medical (Primary Care) Clinic in order to destigmitize mental health care in an attempt to increase access to mental health screening and services. Mental health providers were co-located in the Medical Clinic alongside the clinic's primary care physicians in order to educate them in mental health screening and treatment and to serve as a resource for modification of life style behaviors affecting chronic medical conditions. The challenges presented and the lessons learned from this multidisciplinary collaboration are described.

Results

Multidisciplinary collaboration to integrate physical and mental health services at our institution faced its first challenge in the need to create a primary care clinic practice model. Many of our primary care providers were unfamiliar with standardized tools available to screen for depression, anxiety or substance abuse and/or felt uncomfortable diagnosing and treating patients with psychiatric illness due to lack of training, experience, interest, or the belief that it was not their role as internists. From the outset, it would have been easier to create a Mental Hygiene Clinic within the Medical Clinic but that would not have achieved our goal of integration even if it allowed for some degree of multidisciplinary collaboration. There was also the risk that resistance by primary care providers might devolve our efforts into such an arrangement ("clinic within a clinic"). Despite general agreement among primary care providers about the benefits of integration when presented with the program, it was insufficient in countering initial resistance. Overcoming resistance from primary physicians requires primary care physician role models and demonstrations of relevance (i.e. case presentations, linking mental health issues/behaviors to medical outcomes). It is also necessary to unravel the lines of authority so that effective collaboration can take place. Ideally, a clinical team leader directs and coordinates the activities of health providers and defines their roles. The team leader maintains multidisciplinary support by providing feedback to the clinical service directors/chairpersons, including identifying barriers to integration. The entire clinical team must be trained in cultural competency and be capable of providing cultural/linguistic support to its service population. Standardized mental health screening tools that require translation must be validated and made available as appropriate.

Conclusions

The delivery of mental health and successful aging in a culturally diverse community is achievable in the multidisciplinary setting of a primary care clinic if it allows for effective integration of physical health and mental health services and cultural competency. The primary care setting has the advantage of providing mental health access to culturally diverse communities for whom mental health screening and treatment is stigmatized.

Clinical and cultural challenges in delivering mental health and successful aging in a culturally diverse community

D. Chen (*USA*)

Baltes and colleague (Baltes & Baltes, 1990) differentiated aging into usual aging and successful aging. They defined usual aging as typical non-pathologic age-associated changes over time and successful aging as functions comparable to their younger age groups. The MacArthur Foundation Successful Aging Research Network and that was published in the book Successful Aging by Rowe and Kahn in 1998, defined the ingredients of successful aging as diet, exercise, pursuing mental challenges, self-efficacy, and social support.

The Flushing Hospital Medical Center (FHMC) started to integrate the mental health ingredients into the physical health care processes in 2002. In 2007, the New York State's Office of

Mental Health awarded FHMC $1.25 million dollar/five year/$250,000 per year integrated care demonstration grant. The grant project serves one of the culturally most diverse counties in the U.S.

The optimal goal of the grant project is to provide successful aging to people from the culturally diverse community through integrated mental health and physical health care. The integrated care reduces the stigma of seeking mental health care, prevents depression and suicide, tailors treatment to age, gender, race, and culture and eliminates racial and ethnic disparities in access to healthcare services, facilitates entry into treatment, and assures that every person will have the opportunity for early and appropriate mental health and physical health screening, assessment, and treatment.

The integrated care and successful aging project is located at the Ambulatory Care Clinic of FHMC. It consists of a physical health team and a mental health team. The physical health team includes attending internists, medical residents, nurses, and nursing aides. The mental health team consists of a psychiatrist as the consultant and educator for the physical health team, an adult nurse practitioner, mental health clinicians, and a patient care coordinator. The two teams are culturally competent in English, Chinese, Korean, Spanish, and Indian. The mental health team provides weekly clinical case conferences and monthly didactic lectures to the physical health team. The physical health team screens, assesses, and treats patients over 50 for mental disorders with both medication management and successful aging techniques. The physical health team consults with and refers patients to the mental health team when necessary. Upon discharge, the nurse practitioner reviews the integrated treatment plan with patients and provides education on successful aging including both physical health and mental health. The nurse practitioner also started the popular Taichi group. Soon it will be available free of charge for the hospital employees. Other established practices include smoking cessation program and weight loss program. The ambulatory care clinic served as the health care home for clients who were matched by ethnicity and primary language spoken with clinicians who are culturally similar to facilitate effective communication and culturally sensitive interventions for successful aging.

The integrated care and successful aging grant project officially started in November 2007. By the end of February 2009, a total of 415 patients were screened and assessed and educated on successful aging at each and every visit to their primary care physician for a total of 1576 visits. Forty-six percent of patients were Hispanics, 10% Whites, 13% African-Americans, 28% Asian-Pacific Islanders, and 2% others. Among them, 69% were male and 31% were female. Sixty-four percent were found to have physical health problems and 33% endorsed mental health issues. Twenty-three percent of the patients scored positive for depression on the PHQ-9, 2% scored positive for anxiety on the GAD-7, and 1% scored positive for alcohol abuse on the CAGE. Twenty-one patients were found to have maladaptive behaviours that negatively affected their physical health. Five percent of the patients were prescribed psychotropics in order to alleviate their severe psychiatric symptoms.

The integrated care and successful aging project increased access to quality care for patients who come from a culturally diverse background. It reduced stigma to mental health. The clinical and cultural challenges included the following two: the first one is to change the physical health team's practicing culture from concentrating more on disease management to focusing on both disease prevention and management, and the second one is to persuade the clients to practice the culturally sensitive successful aging techniques persistently in their daily life.

Other challenges included organizational obstacles, inter-departmental frictions, and inter-disciplinary miscommunications.

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Psychotherapy in geriatrics. A life-review therapy in elderly. A case report

N. Shakhurova (*Russia*)

Introduction

Personal biographies of the elderly represent a serious and research interest both from clinical and humanistic positions. During long life path a person may be a participant of political events quickly becoming historical as well as be a witness of changes of cultural values, accompanying that or another epoch and mainly determining the content of concepts of psychological and psychiatric norm. Alongside with this somatopsychic vulnerability of elder patients inspires clinicians to seek for appropriate measures of assistance able to improve adaptation of patients, which ageing occurs under conditions of changed culture.

From the viewpoint of clinical personology favorable ending stage of life of an individual is characterized by wisdom of experience, feeling of dignity, tolerance and self-control (Semke V. Ya., 2001).

Stopping at the problem of psychotherapeutic coaching of elder patients efficacy of such methods as therapy by review of life events and therapy by recalls should be mentioned (Heyland D.K. et al., 2006; Pot A.M. et al., 2008). Process of recalls and assessment of previous experience plays in present life of an elder person a stabilizing and integrating role. Events of life are processed anew and may be included into current self-esteem. Mentioned psychotherapeutic concepts relate to existential-humanistic ones and are directed at stimulation of possibility of a dialogue, activation of verbal communication with the aim of facilitating the emotional state and psychotherapeutic support. Success of a psychotherapeutic intervention mainly depends on understanding by the therapist of sociocultural peculiarities of the time period which recollections of the patient are addressed.

Introduced below clinical case consists of detailed chronological protocol of life–review therapy, visibly showing picture of personal history against the background of changing cultural context.

A Case Report

Female patient K., 04.05. 1937 was admitted in Affective States Department of Mental Health research Institute on 21.11.2007 with complains on sleep disturbance, anxiety, decreased mood, worsening of the memory for current events, headache, and aches in the area of heart.

Development of this state connects with death of her mother occurred in 2005 at the age of 94 years. Mother of the patient during 11 years was bedridden in connection of fracture of femoral neck in this consequence she was in need of foreign care that was performed by the patient without any assistance. During 2 years after the loss depressed state gradually developed that was described by the patient as a hard sensation of loneliness, absence of meaning of life, disturbance of her usual life style, lack of communication. In autumn 2007 she addressed the clinic of affective states of Mental Health Research Institute according to insistence of acquaintance.

According to diagnostic criteria of DSM-IV she was diagnosed as having dysthymia comorbid with organic asthenic disorder. Disorders of cognitive functions had a mild degree (MMSE - 28 scores).

She was examined by therapist and was diagnosed as having chronic cholecistitis, by oculist – signs of beginning cataract; neurologist – psychovegetative syndrome.

Performed paraclinical investigations (laboratory tests, ECG, USI of organs of abdominal cavity) have not revealed clinically significant deviations.

In association with predominance in clinical picture of depressive affect Sertraline was administered at dose 50 mg daily mornings as well as angioprotective therapy and short course of hypnotics (zopiclon 10 mg nights).

After several days of staying in the clinic patient agreed the proposal of psychotherapeutic treatment along with medication. Methods of psychotherapy included a number of structured interviews in association with basic chronological stages of life as well as discussion of such questions as sensation of maximal fullness of life in past, discussion of most significant social roles (professional, family, public); her own perception of patient of herself and of that in what quality she may be perceived by the others.

Life – review protocol

No family history of manifest forms of psychoses.

Mother of patient, born in 1911 was an elder child in a family having many children having lived in rural area in Ukraine.

In 1931 got married and moved with her husband to Moscow where they worked at an industrial enterprise, performing non-qualified work. Soon after their departure the rest parental family, including four younger sisters was "dispossessed as kulaks" - process of removal of practically entire private property and resettlement to another area, typical for pre-war Soviet time – N. S.). During subsequent two years (1932- 1933) all the relatives died from hunger in association with drought and bad harvest having occurred on the territory of Ukraine in that period of time.

1937 in Moscow, patient was born of which the question is in this clinical case.

In 1941 (three years old) her father was called up where he has been missing. Early in 1942 patient with her mother were evacuated from Moscow to Ural where they lived up to 1944. 1944 (7 years old) after liberation of Ukraine they returned to the motherland of her mother where patient began study at school. 1946 (9 years old) In Ukraine the drought, bad harvest happened again, a real threat of hunger was risen. Mother of patient began to go regularly by train to Lvov (West Ukraine) for exchange of various thins for bread. Soon it has become very dangerous because of revelry of criminality. In the same year patient with her mother moved to Lvov on permanent place of living. Family experienced significant material difficulties; this is why, after graduating from 7-years school, patient entered a building technical secondary school where a stipend was paid.

1957 (20 years old) got married with a young man with whom she met not a long tome. Family of husband has not accepted the daughter-in-law because she was not native of West Ukraine, was regarded as "moskalka", i.e. Russian in origin. 1958 (21 years old) marriage was divorced. 1960 (23 years old) got married once again with a student of a military school. In the same year they moved to place of service of her husband to German Democratic Republic, where they lived up to 1965. In that period of time in association with absence of pregnancy patient was thoroughly examined, gynecological pathology was not found; a supposition about male infertility was stated.

Early 1966 (28 years old) husband of patient was transferred to Siberian Military Okrug, the family has moved to Altai Krai, they lived in military custody in rural area. During departure from Germany to Russia they had a short-term stop in Moscow where the family has adopted a girl at six-month age from a children's home.

1970 (32 years old) family has moved to Novosibirsk, 1980 (42 years old) – to Tomsk, where patient lives up to present time.

Relations with husband and daughter were favorable while the mother of patient annually coming from Lvov to daughter did not experience warm feelings to grand-daughter, always regarded her as unrelated. In period of adolescent age of the girl she informed her about that she was taken from a children's home.

After move to Tomsk patient during 12 years worked as an engineer at an electrotechnical plant. She thought that in association with frequent moves she was a failure to create stable social connections, in the nearest environment there are not people that may be called friends.

1986 (48 years old) experienced sudden death of the husband as a result of a stroke.

1988 (51 years old) daughter of patient got married and began to live separately in the family of husband. In the same year patient has brought her mother 77 years old to permanent place of living to Tomsk.

1992 completed her labor activity, got retired.

1994 (57 years) mother of patient obtained fracture of femoral neck, began be in need of foreign care that was performed by patient during 11 years. Recalling that time she informs about serious physical, moral and material difficulties with which she had to cope. She experienced feeling of insult toward daughter and son-in-law because of absence of assistance.

2005 (68 years) experienced loss of the mother at the age of 94 years after which feeling of being depressed, absence of meaning of life has occurred. Despite of experienced feeling of loneliness and sadness she refused request of the daughter to live together in one flat. She attempted to cope independently with traumatic experiences, was engaged in kitchen-garden, cultivated vegetables and flowers. State has worsened in autumn 2006 after death of the good neighbor. Anxiety began to trouble, sleep was disturbed, and headaches began to be more often. During a year she did not independently address the doctors, thought that to help her in this situation is impossible. In autumn 2007 she addressed clinic of affective states of Mental Health Research Institute due to insistence of her acquaintance.

Results

During medication and psychotherapeutic treatment state of patient became much better: she became more calm, the background of mood became more even, anxiety was reduced, sleep has normalized. She noticed subjective significance of undertaken psychotherapeutic work that helped to complete the work of grief, finally cope with loss, accept the real life situation, promoted improvement of relations with her daughter.

Conclusions

This case study demonstrated biography filled by great number of traumatic events, both at young age and more mature one. These included loss of the father in early childhood, maturation under conditions of stress of a catastrophic scale (war, significant material difficulties, real threat to life); failed attempt to enter another ethnic group; frequent migrations subsequently; difficulties in creation of stable social connections, promoting self-identification in various time periods; difficult microsocial interrelations between related and unrelated relatives; relatively early widowhood; long-term psychotraumatic situation ending with loss of the nearest.

Simultaneously with this, adaptive possibilities of the patient deserve attention that allowed maintaining the satisfactory somatic health throughout the life; also coping-mechanisms were effective promoting independent overcoming of life troubles. Thus, introduced clinical case is an illustration of uneasy life path and, simultaneously with this, a sufficiently harmonious ageing.

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Standard Symposium (SS-VIII-40)

Refugees and Immigrants' Mental Health. The Italian Perspective

Chair: V. Infante (*Italy*); CoChair: D. Berardi (*Italy*)

Community Mental Health Services after the 180/78's Law in Italy. A slow cultural revolution

V. Infante (*Italy*)

In Italy, with Law 180, Mandatory and Voluntary Medical Reviews and Treatment, of 13 May 1978, which was later incorporated into Law, 833/78 of 23 December which was established the National Health System, provided for the closing down of mental hospitals and the use of coercive treatment. In the next years the psychiatric services were established through the "Objective Protection of Mental Health Project", which was designed according to the community mandatory medical services model falling under the scope of the National Health Service. These are established institute: the Department of Mental Health, whose territory usually coincides with that of the Local Health Unit, that manage and coordinate mental health services; the Mental Health Centres, which are mostly open 12 hours a day and engage in counselling-liaison services and therapy; the Psychiatric Diagnosis and Treatment Services, which are located in general hospitals for the emergency hospitalization or for serious cases; the Day Hospital, usually related to CSM for more intensive care or care to PDTS post-discharge by PDTS; the Day Care Centres, are usually connected to CSM therapists for the implementation of residential care projects that can be provided daily without hospitalization; the Therapeutic-Rehabilitative and Socio-rehabilitative Residences, which range from complex therapeutic and rehabilitative Communities to simple residential communities.

This system has big advantages (such as psychiatric services throughout the territory), but also serious critical points (the relationship with the users is too much mediated by the Institution). The natural offspring of the 180's community psychiatry model has been really realized particularly in the LHU of Trieste and in Caserta/2 (it is located near Naples), were existed MHC that cover the territory 24 hours a day. Compared to the centres that operate 12 hours a day, the CSMs can accommodate till 4 patients in ad hoc Reception Centre for conditions requiring continuous clinical assistance and greater surveillance than in residential care provided by nurses that rely on the hospital model and psychiatrists on call (availability) for the RC, on STRs and on Hospital emergency rooms in the proximity (for emergencies or for consultation). This organization, besides providing many advantages to users, is particular for the cost of each MHC, that is each about 1/6 compared with those of one of the Private Psychiatric Care Clinics (typically presents in the Middle and South of Italy) having the same daily movement of people. The worst handicap of these private clinics is that they are organized on the model of Rest Homes for the elderly with too many patients and insufficient surveillance.

The bio-psycho-social trauma of migration. A case report

S. Ferrari (*Italy*)

Background

The process of migration has often been described as a "trauma", with psychic consequences possibly conceptualized as post-traumatic stress disorder. As many clinical and extra-clinical variables are involved (classified as occurring pre-, during- and post-migration, Bhugra, 2003), there is a need for a better understanding.

Methods

A case report is described and discussed, under the joint perspective of three different approaches

to human suffering, namely that of a neuro-rehabilitation physician, a psychiatrist and a social worker.

Results

M. B. is a 36 year-old male, single and high school-educated, who migrated from Morocco to Italy in 2003. In 2006, he fell accidentally from a scaffolding at work, causing himself a traumatic brain injury with transient loss of consciousness, occipital fracture and bilateral frontal haematomas. He was admitted to hospital, recovered full consciousness within few hours and was discharged home the following day. He was then taken in charge by the Social Services of the National Work Insurance Scheme (INAIL). Over the next few months, he started complaining of symptoms never experienced before (according to him), such as multi-sensorial pseudo-hallucinations and hallucinosis, together with changes in character and behaviour, demoralisation, insomnia. Slight paranoid ideation was present too. The patient was considered too disabled to go back to work. Post-traumatic epilepsy was ruled out and M.B. was referred to psychiatry. A psychiatric diagnosis of adjustment disorder and pre-morbid personality narcisistic disorder was established, with indication to supportive psychotherapy and antidepressant drug treatment, but after few sessions he interrupted contacts. Following this, he was referred to a neuro-rehabilitative outpatient service, where a comprehensive neuropsychological examination was undertaken, showing severe dysexecutive syndrome with severe behavioral disturbance. Attention deficits and verbal working and long-term memory impairments were observed too. He refused any specific cognitive rehabilitation program. During the following year, his behavioural disturbances worsened and, notwithstanding his extremely good introspective abilities, his overall personal and social functioning declined markedly. A strong integration of neuro-rehabilitative, psychiatric and social interventions was established to deal with M.B.'s complex needs.

Conclusions

In the experience of M.B., the biological head trauma pairs with the social trauma of migration and the psychological trauma of forced interruption in the migration parabola. The interrelated meanings of trauma – breaking up of a psycho-somatic balance with consequences on cognition, emotions, behaviour and social functioning – require a narrative and collaborative approach to care, addressing complex bio-psycho-social needs.

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Methodology and Praxis in Clinical Ethnopsychiatry for Public Mental Health Services. The Italian Situation

S. Inglese (*Italy*), G. Cardamone (*Italy*)

In the last few years, some italian Mental Health Departments have developed critical remarks and experimental operating on clinical management of mental disorders and psychotherapeutic devices addressed to immigrant individuals, families and groups. The present phase is marked by some methodological approaches of intervention (in prevention, therapy and rehabilitation) suited to the complex phenomenology of morbidity tested in psychiatric observation. This essay offers an overview on the main methodological issues and frequent operative questions related to the construction of new topics in Italian work on ethnopsychiatry (diagnostic classification, innovations in clinical devices, linguistic and cultural mediation, culturally oriented psychotherapy, multidisciplinary interaction between anthropology, linguistics and psychopathology, ethnopsychopharmacology etc.).

Moreover methodological and operative questions are reviewed from the perspective of Italian National Ministry of Health's outlines for the protection of immigrant's mental health.

Theory and praxis of transcultural psychiatry in community mental health. Experiences in Calabria and Toscana

G. Cardamone (*Italy*), S. Inglese (*Italy*)

The complexity of clinical aim for transcultural Italian psychiatry forces the urgent creation of some experimental centres of excellence dedicated to research, training and health care of migrant populations.

This new scientific foundation could really reduce the waiting time to discover new and necessary clinical findings. This new system could be convenient to renew, deeply and widely, theories and practices involved in transcultural psychiatry field whom must be integrated systematically with public mental health services and university psychiatry (review of training programs for new specialists).

Positive outcomes has been observed both in ordinary clinical practice in conventional public health centres (i.e., Operative Units in Mental Health Departments for Adult and Child-Adolescents; Catanzaro – Calabria, Firenze e Prato - Toscana) and facing Psychosocial Mass Emergency (Inglese, 2002), in weak and contingent systems of integration between public institutions and social voluntary programs (ex. Refugee welcome programs for welfare and psychosocial integration Badolato, Calabria; Borgo San Lorenzo, Toscana; Harrag, 2007; Inglese, 2005).

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Plenary Session (P-9)
The Future of Cultural Psychiatry
Chair: G. Bartocci (*Italy*); CoChair: W.S. Tseng (*USA*)

Bio-cultural connections in psychopathology. New looks
R. Alarcón (*USA*)

The need for a comprehensive approach to the clinical realities of psychiatric patients demands serious attempts at the study of correlates between different types of disciplines and their corresponding tools. Such is the case between biology and culture in the study of psychopathology. It has been said that cultural constructs have a biological foundation, but also that biological assumptions are, in the last analysis, products from a culture and its historical evolvement.

This presentation reviews the current state of knowledge about eventual correlations between cultural events or culturally-determined human experiences and biological changes either preceding or following the actual clinical occurrences. Western approaches to the study of emotions are initially presented. Basic conceptual, methodological, and experimental issues are then examined, followed by clinical areas in which these links can be demonstrated. From specific entities (i.e. posttraumatic stress disorder, eating disorders, chronic pain) to general but pertinent situations (i.e. resiliency, developmental issues, personality disorders, culture-bound syndromes, or self-mutilating behaviors), the analysis is expanded to therapeutic areas including examples such as the impact of psychotherapy on genetic expressiveness, or the ethnic bases and findings of pharmacology and pharmacogenomics. Some of the most recent contributions of studies based on genetics, biochemistry, pathophysiology, or neuroimaging are described, with emphasis on general neural circuits, and specific hemispheric and neuro-anatomo-physiological locations, whenever possible.

Specific examples of current lines of study and research constitute the last part of the presentation. As an example, the process of change in the psychotherapeutic process is examined. Psychotherapy is, in many ways, a sophisticated cultural product with a respectable universalistic application. Hypothesis generating analysis provide useful information, for instance, in the search of potential mediators of behavioral and emotional changes. Issues of temporal precedence and correlations are central to this inquiry. The so-called transduction modalities: culture-mind; mind-brain; brain-cell; cell-gene, are undeniable components of what in a rather simplistic manner is called "genetic-environmental interactions." In psychotherapy, a moderator precedes treatment; a mediator occurs during treatment: in both cases, a cultural ingredient assists and affects the intensity of the response with eventual bio/physiological and behavioral changes.

At the root of these types of studies, Kendler's explanatory pluralism is a powerful stepping stone towards continuous efforts of integration, in order to consolidate the end of an obsolete Cartesian dualism.

Integrating education, consultation, and research in cultural psychiatry's future

J. Bohenlein (*USA*)

Cultural psychiatry faces a very promising future as the medical and psychiatric community, educators, governments, and health policy makers have begun to recognize the importance of cultural and ethnic factors in psychiatric assessment and treatment. A major challenge for cultural psychiatry is to continue to articulate the importance of cultural factors in all areas of psychiatry and medicine.

Cultural psychiatry must contend with incredible diversity in world view, philosophy, social structure, spirituality, gender roles, generational relationships, and meanings of identity. In the research realm, there is a large need to continue to develop reliable and valid research instruments that can be used cross-culturally. In order for this to occur, proper training of researchers is essential. But this requires more that just adequate funding. What is just as important is a cross-fertilization of education and discourse among the social sciences, psychology, and psychiatry. The polarization that has long existed between anthropology and psychiatry, for example, does not fit the reality of what is required in present-day cross-cultural epidemiological or qualitative research.

Education of the public, health professionals, and trainees in medicine and the social sciences also is essential for the future of the field. Besides improving care to individuals and families, cross-cultural research and education also have great potential to inform the data available to health care policy makers in decisions regarding funding and prioritization of health care initiatives. For instance, valid data about the prevalence or incidence of a specific disorder in a particular ethnic or cultural group can lead to more appropriate attention to the development of public education and care initiatives. And, research that has been informed by social science perspectives may have a greater chance of accurately influencing more culturally appropriate public education initiatives that contribute to primary prevention, and also to the design of health programs that optimize both access to care and acceptance within a cultural community. All of these factors working together also can reduce disparities in mental health care and reduce stigma towards mental illness both inside and outside cultural communities.