Psychiatric Care Across Cultures

WTA Transcultural Psychiatry Section Symposium 2003

November, 9th - 10th 2003
Malta

ISBN: 99909-44-24-5

Welcome
Author Index
Overview
Organisation
Paper Contents
Sponsors

Conference Organisers

Overall Organising Bodies

TPSection, World Psychiatric Association
University of Mata
Caretranslate International Network
Italian Institute of Transcultural Mental Health

Chair

Dr Goffredo Bartocci,
Chair, World Psychiatric Association Transcultural Psychiatry (TP) Section,
Chair Italian Institute of Transcultural Mental Health.
tpsection@quipo.it

Co-Chairs

Prof Ron Wintrob
Co-chair TP Section
Brown University, USA
rwintrob@earthlink.net

Dr Charles Pace
University of Malta
Caretranslate International Network
charles.pace@um.edu.mt

Local Conference Organisers

Chair:

Dr Charles Pace

Organising Body:

Malta University Services Ltd.

Scientific Committee Members

Dr. M. Beiser
University of Toronto
Canada

M.F. El-Islam
University of Cairo
Egypt

C.Haasen
University of Hamburg
Germany

A. Javed
World Islamic Association of Mental Health
Cairo
Egypt

S. Jadhav
Centre for Medical Anthropology
University College London
UK

W. Jilek
University of British Columbia
Vancouver, BC
Canada

D. Kinzie
Intercultural Refugee Program
Oregon Health & Science University
USA

R. Littlewood
University College London
UK

J. Obiols
Mental Health Services
Andorra

F. Noda
Taisho University
Tokyo

R. Prince
McGill University
Montreal
Canada

W.S. Tseng
University of Hawaii
Honolulu

V.Varma
Columbia University College of Physicians and Surgeons
USA

M.Weiss
Swiss Tropical Institute
University of Basel
Switzerland

For Caretranslate Section:

Mark Agius,
Bedfordshire and Luton Community NHS Trust, UK

Olwyn Gallagher
Cambridgeshire & Peterborough Mental Health Partnership NHS Trust, UK

Rashid Zaman,
BLCT & Department of Psychiatry, University of Cambridge, UK

Local Sponsors

Ministry of Health

Ministry of Social Policy

Ministry of Foreign Affairs

Wyeth / Vivian Commercial Corporation

Associated Drug Company

Lundbeck

WPA Transcultural Psychiatry Section Symposium 2003

Saturday November 8
Time: 20.00
Place: Palazzo Parisio, Valletta
Welcome Reception, courtesy of Ministry of Social Policy, Ministry of Foreign Affairs

Sunday November 9
Time: 09.00
Opening Remarks: Goffredo Bartocci, Chair WPA TP Section
George N. Christodoulou, WPA Secretary for Sections

Symposium S1 – Looking Back and Looking Ahead; Research in Cultural Psychiatry

Sunday November 9
Time: 9.30 – 11.10
Room: Sonata Suite 2
Chair: Ronald Wintrob
Co-Chair: Mitchell Weiss

S1-1
Issues in Refugee and Immigration Psychiatric Care
David J. Kinzie

S1-2
Psychiatric Epidemiology and its Contributions to Cultural Psychiatry
Robert Kohn

S1-3
Psychotherapy in Psychiatry Education: Today and Yesterday
Edward F. Foulks

S1-4
Religion and Spirituality in Psychiatric Care
James K. Boehnlein

11.10 COFFEE BREAK

Symposium S2 – Migration, Asylum, Refugees

Sunday November 9
Time: 11.25 – 13.00
Room: Sonata Suite 2
Chair: James Jaranson
Co-Chair: Marianne Kastrup

S2-1
Tortured And Traumatized Somali And Ethiopian Refugees In Minnesota: Reactions To 9/11 And Subsequent Retraumatizing Events
James Jaranson, Cheryl Robertson, Marlene Spring, Joseph Westermeyer, James Butcher, Linda Halcon, David R. Johnson, Kay Savik

S2-2
Mental Health Care Programs for Refugees
Johannes G.B.M.Rohlof

S2-3
Seeking Asylum, Accumulating Stress
Rolf V. Schwarz, Marjan C.M.Mensinga

S2-4
Mental Disorders Among Migrants and Refugees from Chechenya and Central Asia in Russia
Caesar Korolenko, Nataliya Dmitriyeva

13.00 – 14.30 LUNCH BREAK

Symposium S3 – Cultural Psychiatry in Sub-Saharan Africa

Sunday November 9
Time: 14.30 – 16.10
Room: Sonata Suite 2
Chair: Roland Littlewood
Co-Chair: George Christodoulou

S3-1
Towards an Afrocentric Approach to Psychiatry
Dan Lamla Mkize

S3-2
The Budda Syndrome (Hmman Budda)
Tzeggai Berhe

S3-3
Dissociative Symptoms and Reported Trauma among Patients with Spirit Possession and Matched Controls in Uganda.
Marjolein van Duijl, Ellert Nijenhuis, Ivan Komproe, Joop de Jong

S3-4
The validity of DSM-IV dissociative disorders categories in SW Uganda
Marjolein van Duijl, Etzel Cardeña, Joop de Jong

16.10 COFFEE BREAK

Symposium S4.1 – Theoretical Issues in Transcultural Psychiatry

Sunday November 9
Time: 16.30 – 18.15
Room: Sonata Suite 1
Chair: Thomas Stompe
Co-Chair: Johannes Rohlof

S4.1-1
Are Explanatory Models of Mental Illness Disease-or Culture-specific?
Thomas Stompe, H. Schanda, W. Zitterl, K. Ritter, G. Ortwein-Swoboda, H.R. Chaudhry, F. -S. Kohl

S4.1-2
Cultural Sensitivity in Psychiatric Diagnosis
Johannes G.B.M.Rohlof
S4.1-3
Ethnic and Gender Differences in Mental Ill-health
Mustafa G. Soomro, Sara Arber

S4.1-4
Tolerance in Crosscultural Societies
Johanna M. Tamm

Symposium S4.2 – Research and Clinical Issues in Transcultural Psychiatry

Sunday November 9
Time: 16.30 – 18.15
Room: Sonata Suite 2
Chair: Mitchell G. Weiss
Co-Chair: Caesar Korolenko

S4.2-1
Cultural Epidemiology of Suicidal Behaviour
Mitchell G. Weiss, S.R. Parkar, A.N. Chowdhury

S4.2-2
The Value of Qualitative Evaluation Of A Cultural Consultation Service
Danielle Groleau, Laurence J. Kirmayer, Caminee Blake

S4.2-3
Affective Disorders in the Structure and Dynamic of Mental Disorders with Brief Duration in Siberian Turks
Caesar Korolenko, Khusain Muhomedzianov

S4.2-4
Differences Between Albanian and Greek Women that Developed Post Partum Depression During the First Three Months of Puerpartum
Fragiskos Gonidakis, A. Rabavilas, G. Kreatas and G. Christodoulou

Sunday November 9
20.00 Gala Dinner Golden Tulip Vivaldi

Symposium M1 – Psychiatric Effects of the Recent Iraqi War

Monday November 10
Time: 9.30 – 11.30
Room: Sonata Suite 2
Chair: J. David Kinzie
Co-Chair: James K. Boehnlein

M1 -1
An Overview of Cultural Issues in PTSD
James K. Boehnlein

M1 -2
The Effects of the Iraq War on Refugee Psychiatric Patients in Sweden
Riyadh al-Baldawi

M1 -3
Impact of the Iraqi War on Traumatized Middle Eastern and Bosnian Refugees
Pamela Edwards

M1 -4
The Effects of the Iraq War on Psychiatric Patients in Baghdad
Raghad Sarsam

M1-5
The Effects of the Iraq War on Palestinian Patients:
What Factors Make People Resilient or Vulnerable in Crises?
Iyad Zaqout

11.30 COFFEE BREAK

Symposium M2 – The Influence of Jewish Culture on Psychoanalysis and Transcultural Psychiatry

Monday November 10
Time: 11.50 – 13.15
Room: Sonata Suite 2
Chair: Micol Ascoli
Co-Chair: Ronald M. Wintrob

Introduction: Goffredo Bartocci

M2-1
The Influence of the Jewish Culture on Freud and the Development of Psychoanalysis
Micol Ascoli, Vincenzina Iannibelli, Vittorio De Luca, Giancarlo Peana, Ugo Lancia, Maria Grazia Mazza

M2–2
The Mystical Roots of Psychoanalytic Theory.
Simon Dein

M2–3
Reflections on the Influence of Jewish Culture on Transcultural Psychiatry
Ronald M. Wintrob

13.15 – 14.15 LUNCH BREAK

Monday November 10
Time: 14.15 – 15.15
Room: Sonata Suite 1
TP SECTION COMMITTEE MEETING

Symposium M3.1 – Multicultural Mental Health Services in Europe I

Monday November 10
Time: 15.15 – 17.15
Room: Sonata Suite 1
Chair: Goffredo Bartocci
Co-Chair: G.N.Christodoulou

M3.1–1
Migration and Schizophrenia. An Ongoing Study in Andorra
Joan Obiols, N.Cerulla, E. Bayona

M3.1–2
Cultural Psychiatry and Services Organization:
Is the Canadian Model Applicable to the Italian Context?
Vittorio De Luca, Vincenzina Iannibelli, Micol Ascoli

M3.1–3
Cultural Identity, Acculturation and Mental Health
A School Based Population Study of Adolescents in East London
Kamaldeep Bhui

M3.1–4
Acculturative Stress and the Intergeneration Conflict in Immigrant's Families with Middle East Origin
Riyadh al-Baldawi

M3.1–5
The Incidence of Schizophrenia Among First and Second Generation Moroccans in the Netherlands
T. Zandi, J. Havenaar, R. Kahn, A. Limburg

Symposium M3.2 – Multicultural Mental Health Services in Europe II

Monday November 10
Time: 15.15 – 17.15
Room: Sonata Suite 2
Chair: Joan Obiols
Co-Chair: Marianne Kastrup

M3.2–1
Mental Health Services for immigrants in Denmark: problems and challenges
Marianne Kastrup

M3.2–2
Differences Among Patients of a Transcultural Psychiatry Outpatients Clinic According to Ethnicity
Fragiskos Gonidakis, K.Kattan, A.Takad, D. Ploubidis, G.N.Christodoulou

M3.2-3
The Provision of Culturally Appropriate Services in a Multi-ethnic Community for Patients Suffering PTSD A Report from East London
Patricia d'Ardenne, N. Capuzzo, W. Fakhoury, S. Priebe

M3.2-4
Migrant Health Issues as Interpreted in Modern English Literature
Maurice Cauchi

17.15 COFFEE BREAK

Symposium M4 – Psychiatry or Spirituality?

Monday November 10
Time: 17.30-19.00
Room: Sonata Suite 2
Chair: Ronald Wintrob
Co-Chair: James K. Boehnlein

M4–1
Limits to Agency in Trinidad and Albania
Roland Littlewood

M4–2
The Cultural Construction of the Spiritual Self: The Biopsychocultural Threshold Triggering Trance States
Goffredo Bartocci

M4–3
Prayers and Healing
Armando Favazza

M4–4
Religious Beliefs, Practice and Coping with Mental Distress: A Qualitative Analysis Across Ethnic Groups in the UK
Kamaldeep Bhui

M4–5
Altered States of Consciousness in Traditional Healing in Nepal
Dagmar Eigner

Monday November 10
Time: 19.00-20.15
Room: Sonata Suite 1
TP Section Business Meeting

WPA Transcultural Psychiatry Section Symposium 2003

Table of Contents

Symposium S4.2 – Research and Clinical Issues in Transcultural Psychiatry

Symposium M1 – Psychiatric Effects of the Recent Iraqi War

Symposium M2 – The Influence of Jewish Culture on Psychoanalysis and Transcultural Psychiatry

Symposium M3.1 – Multicultural Mental Health Services in Europe I

Symposium M3.2 – Multicultural Mental Health Services in Europe II

Symposium M4 – Psychiatry or Spirituality?

Welcome Message to Conference Participants

This message of warm welcome to all of you who have come to Malta to participate in the Conference Week devoted to the theme of Psychiatry Across Cultures, represents the culmination of a year of discussion and planning, of hopes and dreams. The organizations and institutions sponsoring this Conference Week searched for a location that could uniquely represent the aspirations of Transcultural Psychiatry in a changing world; a place with a long historical tradition of being at the crossroads of intercultural communication.

Malta has been strategically important for millennia as a centre of trade, commerce and the exchange of ideas that accompanies trade, as well as a crucially important bastion in the middle of the Mediterranean, controlling the sea lanes between Europe, Asia and Africa. It stands both symbolically and literally between northern and southern hemispheres and between Eastern and Western cultural traditions. It has been strongly influenced by the civilizations of Greece, the Middle East, Rome and Britain. But it has made of those influences and its own resilient tradition, a place uniquely itself; as you will learn for yourselves during this week as the guests of our Maltese hosts.

We would like to recognize and to thank the following organizations and institutions for making this Conference Week come to fruition: The World Psychiatric Association, the WPA Transcultural Psychiatry Section, Caretranslate International Network, The Italian Institute of Transcultural Mental Health, the Community of Narni (Italy), the University of Malta and the Government of Malta. Without the generous support of all these institutions and their support staff, this Conference Week could not have been achieved.

The kind support and enthusiasm of all of you who are participating in this Conference Week is also very important for us. I would like to say a word of special thanks to all TPSection members who, as always, have supported the TPSection Symposium, and, in so doing, have made possible this Conference Week as a whole, enabling us to pursue the task of developing Transcultural Psychiatry around the world.

The theme of this Conference Week is Psychiatry Across Cultures. The theme reflects the fundamental purposes of Transcultural Psychiatry; to contribute to the understanding of human diversity, to assert and support the uniqueness of different cultural traditions; and to work toward individual, family, group and societal well-being.

This conference has been designed to encourage the exchange of ideas among people in the healing professions and those in the social sciences; between colleagues from countries and cultural regions around the world.
We, the organizers of this Conference Week, have wanted to facilitate communication and stimulate dialogue among those who will be shaping the future of the helping professions and related social sciences.

It is apparent to us, as we have received and reviewed the great diversity of titles, abstracts and papers that will be presented here this week that the goals we have set ourselves have been wonderfully realized in the papers all of you have contributed.

Accordingly, and on behalf of the Scientific Organizing Committee, we thank you all for coming to Malta this week to participate in this conference.

Goffredo Bartocci, *Chair, WPA TP-Section and Conference Chair*
Ronald Wintrob, *Co-Chair WPA TP-Section and Conference Co-Chair*
Charles Pace, *University of Malta and Caretranslate; Conference Co-Chair and Local Organiser*

IMMIGRANTS AND REFUGEES, THE PSYCHIATRIC PERSPECTIVE

J. David Kinzie, M.D.

Intercultural Psychiatric Program at Oregon Health & Science University

Oregon Health & Science University
Department of Psychiatry
Intercultural Psychiatric Program
3181 SW Sam Jackson Park Road, UHN-88
Portland, OR 97239-3089
503-494-4222
Fax 503-494-6143
kinziej@ohsu.edu

ABSTRACT

In the period following the Indochina war until September 11, 2002, a large number of refugees came to the United States in a planned, legal manner. Many of these people came after and during brutal civil wars and long refugee camp experiences. Those from Vietnam, Cambodia, Bosnia, Somalia and Afghanistan had fled from well-publicized war zones. Less known were the asylum seekers from African countries and many illegal refugees from the wars and violence in Central America, i.e. Guatemala, Nicaragua, El Salvador, and Columbia. Many of these groups developed psychiatric symptoms and were evaluated and treated in our Intercultural Psychiatric Program in Portland, Oregon, USA. The most common disorder found was PTSD usually with comorbid depression; a substantial minority had psychotic symptoms or frank schizophrenia. Treatment emphasized a long term approach with ethnic counselors/interpreters and a constant psychiatrist providing psychotherapy and medication. The advent of 9/11 and the subsequent wars in Afghanistan and Iraq has had a profound effect on the symptoms of these patients; while the Patriot Act and increased scrutiny of immigrants has resulted in a marked reduction in the number of refugees entering the U.S. and greater uncertainty for their families. This paper is a review presented in a historical perspective of recent terrorist activities and their impact on the psychiatric health of refugees.

1. IMMIGRANTS

Migration has been a long time human activity usually to seek economic improvement. This has occurred currently in both legal and illegal paths, between countries and also within a single country. Large scales migrations occur in the United States from Central and South America and in Europe from Africa and Asia. The amount of legal migration in the United States has varied greatly over the last 150 years. For the decade ending in 1890, over 5 million came to the United States compared with only 500,000 for the decade ending in 1940. It is estimated that 10,000,000 legal immigrants have come to the United States in the decade ending in 2000 (Immigration and Actualization Service Data).

Perhaps the largest migration has occurred within one country, China. These are about 120,000,000 migrant workers, only about half who are registered (Thanes, 1998). This has been described as planned and unplanned dichotomy (Fann). Unplanned migrants received no services and make public health issues, such as AIDS difficult to monitor.

Early in American psychiatry it was reported that foreign born had an increase rate of mental illness compared to native born. Odegaard, (1932) classic study in Minnesota found a much higher admission rate in the state hospitals, for Norwegian born compared to Native born. and even a higher rate compared with Norwegians in Norway. This lead to competing theories of migration; the medically vulnerable migrate verses immigration and acculturation are stressful in leading to mental illness. This has lead to a large number of studies on the rates of mental illness among immigrants without clear conclusions. Schizophrenia has reported higher in African-Carribean population in England perhaps related to cultural variations in symptom reporting (Sharpley et al., 2001). Increase rates of schizophrenia like psychosis was found in immigrants, higher from East Africa in Sweden but others felt that it was due to the migration process (Zolkowska, 2001). A Danish study found that migration confers an increase risk for schizophrenia not attributable to selection factors (Cantor-Grace, 2003). An earlier Danish study found that an increased rate of schizophrenia among migrants but was due to individuals born in neighboring countries (i.e. transit migration). (Mortensen, 1997).

Some immigrant groups to the Netherlands had a higher rate of schizophrenia. (Moraccan, Surinan, and Netherlands Antilles) but not others (Turkey and Western countries) (Selten, 2001). A study in Rotterdam found similar results but only males from Morocca, not females, had increased treated incidents of schizophrenia (Schrier, 2001). The high incidents of Surinamese in Netherlands were found on further evaluation not to be related solely to selective migration.

A study in Israel found a considerable variation rates for schizophrenic behavior from different countries of origin but migrants were older at the time of hospitalization – suggesting immigration had a delaying effect on admission (Rabinowitz, 2002).

For other than schizophrenia, a report found Sardinian immigrants to Paris had a higher rate of depression and anxiety disorders (Carta, 2002). The second generation was particularly at risk for depression, drug abuse and bulimia. Treated prevalence rates of mental illness in Australia were highest among those born in Greece and lowest among those born in UK, Ireland or Southeast Asia (Stuart, 1998).

Studies involving Trinidad immigrants to London found that migration produces higher stress, but rates of schizophrenia are even higher among second generations (Bhugra, 2000) suggesting that social factors such as cultural identity and racisms are factors in the genesis of schizophrenia.

PTSD survivors of World War II in the Netherlands were compared to Dutch who immigrated to Australia. PTSD was more common in the immigrant group, but PTSD was comparable in both groups supporting the concept that severe stress (past war experience) not migration was a major factor in PTSD (den Velde, 2000).
The Mexican immigrants to the United States are a heterogeneous group. The Mexican

Indians had a different risk of affective disorders and alcohol/drug dependents than non-Indians. Mexican Indians seem to be more vulnerable to exposure to U.S. society (Alderate, 2000).

Among the 5 million Hispanics in the United States, Mexican-Americans compared to non-whites were less likely to have a psychiatric diagnosis (Ortega, 2000). Acculturation stress had a greater risk of DSM-IIIR diagnosis for Mexican-Americans than other Hispanics. There was greater risk of having a substance abuse disorder among Puerto Ricans. Escobar & Vega (2000) point out acculturation itself is a fuzzy concept often meaning stressful life experiences after cultural change.

Implications of recent research on migration

1. From Odegaard's original study, current evidence indicates migrants do not necessarily have a higher rate of schizophrenia. The rates vary and seem low compared with native born when sending and receiving countries are similar (Western to Western) and higher when sending and receiving countries are dissimilar (Surinan to Netherlands) (African Caribbean to England). Selection factors don't explain this entirely implying that there is something stressful about migration but variation in diagnosis and racism may also be a factor.

2. PTSD doesn't seem to increase with migration but may influence the choice to immigrate. Other psychiatric disorders may increase in emigrants but second generation may show an increase risk. The process of cultural change in acculturation may be more stressful and lead to increase rates of non-psychotic disorders.
3. There is such a large ethnic and individual variation that immigrant status doesn't necessarily help in any single individuals diagnosis and treatment.

2. REFUGEES

In 2002, there were 19.8 million refugees in the world, i.e., those fleeing their own country because of war, ethnic cleansing, or starvation (UNCHR). It is estimated that there's another 20 million internally displaced people not counted as refugees. The largest number of refugees is in Asia (8.8 million) and Africa (4.1 million). The main host countries are Pakistan sheltering 2.2 million, Iran 1.9 million and Germany almost 1 million.

The largest number of refugees was as of 2000 from Palestine and Afghanistan. The internally displaced persons are highest in Sudan, Angola, Columbia and Cango.

The Indo China war resulted in 700,000 refugees from Vietnam, Cambodia and Laos (Mollica, 1994). The civil war in Nicaragua, El Salvador and Guatemala displaced 2 million people (Farias, 1994). Two million were also displaced from the former Yugoslavia (Leopold & Harellbond, 1994).

Since the studies of the holocaust victims of World War II, it was known that massive psychological trauma could cause disturbing psychiatric symptoms, sometimes referred to as the concentration camp syndrome (Kinzie & Goetz, 1996). It wasn't until the publication of DSM –III in1980 when the criteria for post-traumatic stress disorder was formulated that studies of traumatized refugees

could objectively begin. The first report to PTSD and PTSD to my knowledge was our work with Cambodian refugees published in 1984 (Kinzie et al., 1984). Since that time multiple studies with different refugee groups have documented high rates of depression and PTSD. They have included other studies on Cambodians (Kroll, 1989; Cheung, 1994) and Carlson & Rosser-Hagan, 1991). Vietnamese and Mien (Kinzie et al., 1990). Chilean and Salvadorian refugees (Thompson & McGarry, 1995) and Ethiopian Jews immigrating to Israel (Ariele & Aycheh, 1992).

A community sample of adolescent Cambodians showed half qualified for PTSD and depressive disorder (Kinzie & Sack, 1986). Over time, PTSD tended to persist and remain episodic while depression tended to diminish (Kinzie & Sack, 1989).

The civil war was in Central America, especially El Salvador and Guatemala has produced many thousands of refugees in the United States. Most Salvadorians in a Community Mental Health Center had PTSD and 19% had depression (Molesky, 1986). The Central American refugee women caretakers and their children who witness much violence had increase rates of health problems. Many mothers were unaware of their children's psychological distress. (Loche, 1996). In a through study of Somali refugees in the United Kingdom, anxiety and depression was more common with each pre migration stress, such as shortage of food, loss in a war situation, being close to death and suffering serious injuries (Bhui, 2003). A study in Montreal among Latin American and African refugees found that separation from family as well as trauma had a significant impact on emotional distress (Rousseau, 2001). Political detainees in Vietnam experienced the more torture events in PTSD which was dose related effect and supported evidence that torture is a major risk factor in PTSD and depression (Mollica, 1998). Torture was found to be a risk factor for PTSD after controlling for overall level of trauma exposure among Tamil refugees in Australia (Silove, 2002).

Long-term effects of refugees

Studies are beginning to determine the long-term psychiatric effects of refugees. Among Cambodian adolescence previously reported, the prevalence rate of PTSD fell from 52 to 32% at six years (Sack, 1993). There was some change both ways in the diagnosis and it was not a constant decline. In a three year follow-up study of Bosnian refugees still in a camp in Croatia, 45% of those with PTSD or depression or both, continue to have the diagnosis and 16% asymptomatic developed one or more diagnosis (Mollica et al., 2001). Forty-six who met disability criteria remained disabled and was related to psychiatric disorder. In a population based study of Vietnamese refugees in Australia who have been in the country for over 11 years and almost 15 years of the most severe trauma, about 8% had a mental disorder and trauma exposure increased the risk of mental disorder to 12% (Steelz, 2002).

In a group of 23 severely traumatized and impaired Cambodian refugees treated for over 10 years, 13 were doing well on symptoms and disability ratings but 10 remained moderately to severely symptomatic (Kinzie & Boehnlein under review).

Effects on refugee PTSD after terrorism

Forth-five Asian and Middle Eastern immigrants who were followed up after the Oklahoma City bombing (Trautman, 2002). Prior trauma was predictive of current PTSD symptoms. The graphic T.V. images of 9-11 World Trade Center tower attack provided much anxiety and confusion among patients at the Intercultural Psychiatric Program in Oregon. In a clinical study of Vietnamese, Cambodian, Mien, Bosnian and Somalia refugees, the strongest reaction of fear and increase in nightmares and depression came from the Bosnian and Somalia's (Kinzie, 2002). It was felt that these were refugees from the most recent war and trauma and also the Muslim religion who personally felt more vulnerable. The results of terrorism and the resulting Patriot Act increased security clearance for refugees. Have resulted in dramatic decline in refugees to the United States. In the year 2000, there was a 70,000 quota of refugees, but only 23,000 were actually admitted, meaning long separation for families and even fear for those who have already come to the United States.

Implication

1. There are huge numbers of refugees and internally displaced people in the world.
2. A high percentage perhaps majority have suffered forced migration, starvation, disease, being injured, having close friends or family killed or lost in a war zone with near death experience and direct torture.

3. A high percentage of these (up to 50%) have PTSD and depression and both community and clinical population. This tends to diminish over time with the depression declining more than PTSD.

4. Some people will remain chronically impaired despite intensive treatment. The amount of trauma symptoms from separation from family previous education and work experience will affect outcome in refugees.

5. Refugees remain very vulnerable to future stress especially where violence is concerned as shown by exacerbation of symptoms with the Oklahoma City bombing and the 9-11 T.V. broadcast.

3. ASYLUM SEEKERS

In the past, most refugees who arrived in North America, Europe or Australia were screened prior to arrival. Increasingly, a large number of refugees arriving unauthorized and seeking asylum for protection. In 37 countries reported on by UNHCR there were 587,400 applications for asylum in 2002. The top asylum seeking countries in the world were United Kingdom, USA, Germany, France, Austria and Canada. Per population, Austria, Norway and Sweden were the highest receiving countries. The primary countries of origin were Iraq (51,000) Afghanistan, Federal Republic of Yugoslavia, Turkey and China. In the United States, the largest asylum seeking groups came from China, Mexico, Columbia and Haiti. In the decisions made in the year 2002, 34% of applicants in the United States receive refugee status, compared to 58% in Canada and 14% in Australia.

The data is confusing because of clear differences in asylum seeker between those who have been traumatized and endangered if they return to their own country and those who come for economic reasons often via way of expensive smuggling routes. However, for those who fled war torn areas, the flight of an asylum seeker is difficult, as Derek Silove in Australia has shown. In addition to the marked experiences of trauma, they have an ongoing fear of being repatriated; have barriers to work and social service as well as separation of the families and the uncertain process of refugee claims (Sinnerbrink, 1997). In the United States, asylum seekers are not eligible for services or a work permit until it is judged they could receive a hearing, a process that could take many months. A group of Tamil asylum seekers in Australia did not differ from refugees in pre-migration trauma or symptoms but at a higher post migrating stress related to insecure residency status (Silove, 1998). It was further shown that trauma symptoms variance is 20% for pre-migration exposure and 14% for post emigration status (Steel, 1999).

Concerns about uncontrolled migration have resulted in more restrictive measures for those seeking asylum resulting in detention center and a narrow definition of refugees (Silove, 2000). There are also allegations of untreated medical and psychiatric illness, suicidal behavior, hunger strikes and violence in the asylum seekers. There is a need to inform government officials of the severe effect of these harsh measures that it had on asylum seekers.

Implication

1. The task of sorting out "real" asylum seekers from economic immigrants due to black market of human trafficking is difficult.

2. Among real refugee seeking asylum, the evidence that their traumas is severe and that the stress levels remain high due to uncertain services, residency status and possibility of deportation and long legal proceedings.

3. Repressive government measures have added an increase in desperation and symptomatic behavior.

4. For the United States government response to 9-11 has greatly decreased the number of refugees to United States and put increased pressure and angered Muslims in the United States and refugees from Muslim countries without any noticeable increase in security.

4. CLINICAL IMPLICATION

The data resulted social psychiatry information has greatly expanded our knowledge of immigrants and refugees. There has not been a comparable development of psychiatric services. Many studies have documented low public psychiatric utilization rates by immigrants and refugees. Recently these have included Indochinese (Lam, 1996), Russian refugees (Chow, 1999), Mexicans (Peifer, 2000), and undocumented Chinese and Asian immigrants (Law, 2003) and Asian Americans (1994). The general approach has been to suggest outreach programs and culturally sensitive services (Silove, 1997). This is at a time when cultural assessment has been emphasized as a training requirement

from psychiatrists (GAP). On the other hand, current state budgets have increasing limited mental health services and many have limited psychiatrist's time. The result has been even less services, let alone cultural sensitive ones. Clearly, it is easier to state what needs to be done then it is to do it.

A briefly described example of culturally sensitive program is the Intercultural Psychiatric Program in Portland, Oregon. It is unique in using psychiatrist to treat patients in a comprehensive manner with trained counselors for each cultural group to service as interpreters, case managers and counselors. A variety of services involve socialization groups, rehabilitation services, legal support for asylum seekers and ready access for medical evaluation and above all, a constant doctor-counselor team for each patient. Now there are 1,100 patients from 17 language groups including new services now for children and families. Besides being a service system, it has been a pragmatic laboratory for actual clinical needs and developing acceptable clinical services. Research studies have not promoted services, we now need to develop specialize program for immigrant services and for immigrants and refugees and let the research flow from the actual clinical practices.

PSYCHIATRIC EPIDEMIOLOGY AND ITS CONTRIBUTIONS TO CULTURAL PSYCHIATRY

Robert Kohn, MD

Brown University Department of Psychiatry and Human Behavior
Providence, RI, USA

Butler Hospital
345 Blackstone Blvd.
Providence, RI 02906
Telephone: 401/455-6277
Fax: 401/455-6566
E-mail: Robert_Kohn@brown.edu

ABSTRACT

This paper will examine the contributions that psychiatric epidemiology has made to cultural psychiatry. Psychiatric epidemiology has evolved since in the earliest study conducted by Jarvis in 1855, finding higher rates of mental illness in the pauper classes among Irish immigrants to Massachusetts. Since then psychiatric epidemiology has undergone three generations of evolution. The methodological advances of psychiatric epidemiology have enabled researchers interested in cultural psychiatry to utilize diagnostic instruments and diagnostic criteria that are uniform and measurable. In addition, psychiatric epidemiology has allowed cross-national comparisons across large diverse populations. From a public health point of view these advances have highlighted the tremendous burden that mental illness has placed on all societies, and the need to address mental health issues in all nations and cultures. However, have these methodological advances resulted in a loss of the meaning of culture (the emic) in research on diverse populations? Can instruments be translated and adapted for use cross-culturally across differing groups of people, or do they need to be constructed ground-up as some would argue? Perhaps even a more basic debate is whether or not DSM-IV or ICD-10 can be applied universally? If not how is comparative research even possible, and the main aim of cultural psychiatric epidemiology achieved, the examination of cross-cultural differences to obtain clues toward understanding the etiological factors of mental illness?

A HISTORICAL OVERVIEW OF PSYCHIATRIC EPIDEMIOLOGY

The first attempt to examine the true prevalence of mental disorders in the community was conducted by Jarvis in 1855 in Massachusetts. In his study he included both treated and untreated cases in the community. He examined the frequency of "insanity" and "idiocy", the nosology of his time. Among Jarvis' findings he reported that the Irish were at increased risk for psychopathology, a result due to individuals in the pauper class having 64 times higher of a risk of insanity.

Psychiatric epidemiology has undergone three generations of methodological advancement (Dohrenwend and Dohrenwend 1981). Each generation has differed in its psychiatric nosology and methods of data collection.

The first generation, from the turn of the century to World War II, relied mainly on key informants and agency records to identify cases within the community (Dohrenwend and Dohrenwend 1974). The two main problems with studies of that period were incomplete case ascertainment and the lack of reliability or validity in clinical diagnoses as diagnoses were taken at face value. Furthermore, this period highlights the problems associated with making determinations of prevalence or risk factors from treated cases, as persons in treatment are not a random sample of all people with mental disorders (Kohn et al. 1997).

The second generation, following World War II, used an expanded definition of psychiatric disorders. In addition, community residents were directly interviewed, usually by a single psychiatrist or a team headed by a psychiatrist. Except for a few North American studies (Leighton et al. 1963; Srole et al. 1962), these interviews typically did not employ standardized data collection procedures (Lin 1953). Case identification in the second generation studies was made by psychiatrists following evaluation of protocols collected from the interview data. The second generation of psychiatric epidemiology also used screening scales comprised of symptom items. These scales attempted to distinguish cases from non-cases using cutoff scores. This second generation resulted in a number of advances in psychiatry including: focusing attention to social and cultural influences on mental health; the recognition that there was no single cause of mental illness; the use of the survey method and probability samples of community respondents; and the development of reliable impairment scales used through out psychiatric research today. This second generation had also demonstrated a number of limitations in psychiatric epidemiology. Impairment scales assumed a unitary dimension to mental illness and did not examine specific diagnostic categories. This generation of studies emphasized the role that stress had on psychiatric disorder and ignored other causes such as genetics, infectious, early childhood experience, and biological factors.

The third and current generation emerged with the development of explicit diagnostic criteria and structured clinical interview schedules, both of which contribute to improved diagnostic reliability. Early on the predominant instruments employed included the Present State Examination (PSE) (Wing et al. 1977) geared to the International Classification of Disease (ICD) criteria (World Health Organization 1978), the Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott and Spitzer 1978) which generates Research Diagnostic Criteria (RDC) (Spitzer et al. 1978) for establishing diagnoses, and the Diagnostic Interview Schedule (DIS) (Robins et al. 1981) which uses Diagnostic and Statistical Manual III (DSM-III) criteria (American Psychiatric Association 1980). More recently, new third generation instruments have been developed. The Standardized Psychiatric Examination (SPE) (Romanoski and Chahal 1981), the Revised Clinical Interview Schedule (CIS-R) (Lewis et al. 1990), and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (Wing et al. 1990), which use ICD criteria, largely based on the PSE. The Composite International Diagnostic Interview (CIDI) (Robins et al. 1988), that assesses both ICD-10 (World Health Organization 1992) and DSM-IV (American Psychiatric Association 1994) disorders, were derived from the PSE and DIS. Two major issues facing this third generation of psychiatric epidemiological studies are the validity of the diagnostic criteria and of interview schedules utilizing lay interviewers.

As methodology and diagnostic reliability have evolved with each subsequent generation of psychiatric epidemiology, researchers have been better able to test the association between sociodemographic variables and specific mental disorders. Has this translated into a better understanding of issues in cultural psychiatry?

CULTURE AND PSYCHIATRIC EPIDEMIOLOGY

Psychiatric epidemiology has provided insights into the understanding of mental illness within and across cultural groups. Psychiatric prevalence surveys have been conducted already in nearly all regions of the world, including in some developing countries. These studies have provided some universal truths about mental illness. One, mental illness is highly prevalent and these disorders are among the most disabling medical conditions in both the developed and developing world (WHO 2001). These studies have shown that gender differences across specific psychaitric disorders are nearly universal, such as the 2:1 female to male ratio found for major depression, with rare exceptions (Levav et al. 1997). Schizophrenia has been demonstrated to consistently be more prevalent among individuals in the lower social classes (Dohrenwend et al. 1992; Kohn et al. 1998). The elderly, contrary to earlier beliefs, are now thought to have lower rates of mental illness than younger cohorts (Blazer et al. 1987). Traumatic events that occur to both individuals (Mollica et al. 2001) or in mass, such as through terrorism (North et al. 1999) using psychiatric epidemiology have been shown to have profound effects on mental health. In addition, we have gained new insights into immigration and mental health, such as non-traumatized immigrants may have better mental health outcomes than the second generation (Vega et al. 1998), and that the country one immigrates to may result in differential psychological distress (Flaherty et al. 1988).

Cross-national comparisons have been used in psychiatric epidemiology to provide insights into cultural differences in the risk and outcome of specific psychiatric disorders. The determinants of schizophrenia study from the WHO (Jablensky et al. 1992) raised substantive issues relevant to cultural psychiatry, the possibility that individuals with schizophrenia in developing countries may have better outcomes. A large number of studies using the DIS (Weissman et al. 1997) and the CIDI (Bijl et al. 2003) worldwide have made cross-national comparisons and have shown communalities across countries. The similarities across studies have more meaning than their differences, as the differences can be attributed to methodological variability between studies. The World Mental Health 2000 program is designed to reduce the issue of methodological variability but not eliminate it (Kessler 1999). Are these cross-national comparisons really a contribution to cultural psychiatry?

Can these instruments be translated and validated, and subsequently accurately applied to different cultures? Adapting an instrument for cross-cultural use is often less time-consuming and allows for cross-cultural comparison then developing new instruments to measure similar constructs. The complexity of translating an instrument varies depending on how much the construct being measured differs between the two cultures. Procedures for translating instruments across cultural groups have been well outlined (Sartorius & Kuyken, 1994). The back-translation technique is not beyond criticisms. Bilingual translators may be able to achieve equal back-translations that are not optimal interpretations of the meaning of the item. After an instrument is translated, it is necessary to evaluate the adapted version of the instrument in the target population. Several questions regarding validity and reliability need to be answered before the instrument can be used in a valid manner (Flaherty et al., 1986): content equivalence, are the items that make up the concept in the original culture relevant to the second culture; semantic equivalence, do the translated items have the same meaning in the target culture; technical equivalence, the method of data collection has different results in the target culture; criterion equivalence, how do the results of the adapted version of the instrument compare to independent criteria measuring the same construct; and conceptual equivalence, are the same variables being measured. However, most psychiatric epidemiological studies do not adapt these approaches, but rather an ethnocentric one in which the researcher assumes that the concepts completely overlap in the two cultures. The instrument is used with individuals that

differ from the population in which the instrument was originally developed and normed. This results in the risk of making skewed interpretations of results if the populations differ on some latent variable. One need not look far to find the methodological shortcomings of the now wide spread used large scale psychiatric epidemiological surveys across countries, as rarely are these standards met beyond good faith efforts at accurate translations and small reliability studies (Wittchen 1997). For example, how do we explain the extremely low rates of psychopathology in the China (Wang et al. 1992) and Taiwan (Hwu et al. 1989) studies using the DIS in comparison to other countries, reality or artifact? Advances have been made; researchers in dementia have been successful in developing culturally fair instruments (Hendrie et al. 1995). Therefore, what are reasonable methodological expectations? To conduct validity and reliability studies for each instrument, and on every cultural group would clearly be economically not feasible, and result in a halt in any meaningful epidemiological research.

Early on in the third generation of psychiatric epidemiological research data was collected using mental health professionals (Levav et al. 1993), but now the norm is the lay interviewer and fully structured diagnostic instruments. The current size of the large-scale prevalence studies have resulted in lay interviewers becoming a necessity. Unfortunately, what has been lost is the ability to carefully probe and interpret behavior in a clinically meaningful manner, as responses to fully structured interview schedules are to accepted at face-value regardless of the presenting behavior, e.g. some one who is actively hallucinating but denies it would be recorded as not having a psychotic symptom. Reliability studies examining inter-rater reliability against semi-structured instruments administered by mental health professionals have shown good agreement for many (Ustun et al. 1997), but not all disorders. Psychiatric epidemiology unfortunately has had to compromise the ability to obtain data that is richer in its ability to derive cultural interpretation and meaning for the economics and reality of the research environment.

Perhaps the most important contribution to come out of psychiatric epidemiology, and yet the most controversial, is the use of a universal diagnostic criteria such as that found in DSM and ICD. If one takes the position that psychiatric nosological systems cannot be applied cross-culturally as they are imposed constructs devoid of any meaningful cultural context, then most of psychiatric epidemiology has made little to no contribution to cultural psychiatry. On the other spectrum it may be argued that cultural bound syndromes do not exist, and may even be classifiable within the current nosological system (Lopez-Ibor, 2003). However, psychiatric epidemiology offers the possibility to examine whether symptom criteria differ across different populations, and if symptom criteria can be applied similarly across groups. Only once we have a better understanding of the genetic basis of mental illness, only then can this controversy be resolved regarding whether the phenotypic presentation of mental illness is indeed highly variable across cultures.

CONCLUSION

Psychiatric epidemiology has made sizable contributions to ability to research cultural psychiatric issues and to our knowledge about the field. The expanding use of psychiatric epidemiological methods and the attempts to uniform diagnostic criteria, instruments, and methodology for use in global efforts has led to intense controversy as to whether psychiatric epidemiology has become devoid of any emic or cultural meaning.

REFERENCES

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition. Washington, DC, American Psychiatric Association, 1980

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Washington, DC, American Psychiatric Association, 1994

Bjil RV, de Graff R, Hiripi E, Kessler RC, Kohn R, Offord DR, Ustun TB, Vicente B, Vollebergh WAM, Walters EE, Wittchen HU: The prevalence of treated and untreated mental disorders in five countries. Health Affairs 22:3; 122-133, 2003

Blazer D, Hughes DC, George LK: The epidemiology of depression in an elderly community population. Gerontologist 1987;27:281-287

Dohrenwend BP, Dohrenwend BS. Social and cultural influences on psychopathology. Ann Rev Psychol 25:417-452, 1974

Dohrenwend BP, Dohrenwend BS: Perspective on the past and future of psychiatric epidemiology. Am J Public Health 72:1271-1279, 1981

Dohrenwend BP, Levav I, Shrout PE, et al: Socioeconomic status and psychiatric disorders: the causation-selection issue. Science 255:946-952, 1992

Endicott J, Spitzer RL: A diagnostic interview: the Schedule for Affective Disorders and Schizophrenia. Arch Gen Psychiatry 35:837-844, 1978

Flaherty JA, Kohn R, Levav I, Birz S: Demoralization in Soviet-Jewish immigrants to the United States and Israel. Comprehensive Psychiatry 29:6; 588-597, 1988

Flaherty JA, Gaviria FM, Pathak D, Mitchell T, Wintrob R, Richman JA, Birz S. Developing instruments for cross-cultural psychiatric research. J Nerv Ment Dis. 176:257-263, 1988

Hendrie HC, Osuntokun BO, Hall KS, Ogunniyi AO, Hui SL, Unverzagt FW, Gureje O, Rodenberg CA, Baiyewu O, Musick BS. Prevalence of Alzheimer's disease and dementia in two communities: Nigerian Africans and African Americans. Am J Psychiatry 152:1485-92, 1995

Hwu HG, Yeh EK, Chang LY: Prevalence of psychiatric disorders in Taiwan defined by the Chinese Diagnostic Interview Schedule. Acta Psychiatr Scand 79:136-147, 1989

Jablensky A, Sartorius N, Ernberg G, Anker M, Korten A, Cooper JE, Day R, Bertelsen A: Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization Ten-Country Study. Psychological Medicine (monograph suppl. 20); 1992

Jarvis E: Insanity and idiocy in Massachusetts: report of the commission of Lunacy (1855). Cambridge, Massachusetts, Harvard University Press, 1971

Kessler RC: The World Health Organization International Consortium in Psychiatric Epidemiology (ICPE): initial work and future directions -- the NAPE Lecture 1998. Nordic Association for Psychiatric Epidemiology. Acta Psychiatr Scand. 99:2-9, 1999.

Kohn R, Levav I, Dohrenwend BP, Shrout PE, Skodol AE: Jews and their intraethnic vulnerability to affective disorders, fact or artifact? II: evidence from a cohort study. Israel Journal of Psychiatry and Related Sciences 34:2; 149-156, 1997

Kohn R, Dohrenwend BP, Mirotznik J: Epidemiologic findings on selected psychiatric disorders in the general population, in (Dohrenwend BP ed.) Adversity, Stress, and Psychopathology. New York: Oxford University Press, pp. 235-284, 1998

Leighton DC, Harding JS, Macklin DB, et al: The Character of Danger. New York, Basic Books, 1963

Lewis G, Pelosi AJ. Manual of the Revised Clinical Interview Schedule (CIS-R). London: MRC Institute of Psychiatry, 1990.

Levav I, Kohn R, Dohrenwend BP, Shrout PE, Skodol AE, Schwartz S, Link BG, Naveh G: An epidemiologic study of mental disorders in a 10-year cohort of young adults in Israel. Psychological Medicine 23:3; 691-707, 1993

Levav I, Kohn R, Golding J, Weissman MM: Vulnerability of Jews to affective disorders. American Journal of Psychiatry 154:7; 941-947, 1997

Lin T: A study of the incidence of mental disorder in Chinese and other cultures. Psychiatry 16:313-336, 1953

Lopez Ibor JJ Jr: Cultrual adaptations of current psychiatri classifications: are they the solution? Psychopathology 2003; 36:114-119.

Mollica RF, Sarajlic N, Chernoff M, Lavelle J, Vukovic IS, Massagli MP:.Longitudinal study of psychiatric symptoms, disability, mortality, and emigration among Bosnian refugees. JAMA 286:546-54, 2001

North CS, Nixon SJ, Shariat S, Mallonee S, McMillen CJ, Spitznagel EL, Smith EM: Psychiatric disorders among survivors of the Oklahoma City bombing. Journal of the American Medical Association, 282:755-762; 1999.

Robins LN, Helzer JE, Croughan J, et al: National Institute of Mental Health Diagnostic Interview Schedule: its history, characteristics, and validity. Arch Gen Psychiatry 38:381-389, 1981

Robins LN, Wing J, Wittchen HU, et al: The Composite International Diagnostic Interview: an epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. Arch Gen Psychiatry 45:1069-1077, 1988

Romanoski AJ, Chahal R: The Standardized Psychiatric Examination. Baltimore, Maryland, John Hopkins University School of Medicine, Department of Psychiatry and Behavioral Sciences, 1981

Sartorius, N. & Kuyken, W. (1994). Translation of health status instruments (pp. 3-18). In: J. Orley & W. Kuyken (Eds.). Quality of life assessment: international perspectives. New York: Springer-Verlag.

Spitzer RL, Endicott J, Robins E: Research diagnostic criteria: rationale and reliability. Arch Gen Psychiatry 35:773-782, 1978

Srole L, Langner TS, Michael ST, et al: Mental Health in the Metropolis. New York, McGraw Hill, 1962

Ustun B, Compton W, Mager D, Babor T, Baiyewu O, Chatterji S, Cottler L, Gogus A, Mavreas V, Peters L, Pull C, Saunders J, Smeets R, Stipec MR, Vrasti R, Hasin D, Room R, Van den Brink W, Regier D, Blaine J, Grant BF, Sartorius N. WHO Study on the reliability and validity of the alcohol and drug use disorder instruments: overview of methods and results. Drug Alcohol Depend 1997 47:161-169.

Vega WA, Kolody B, Aguilar_Gaxiola S, Aldrete E, Catalano R: Lifetime prevalence of DSM-III-R psychiatric disorders among rural and urban Mexican Americans in California. Arch Gen Psychiatry 1998: 55:771-782

Wang Holter alcohol book

Weissman MM, Bland RC, Canino GJ, Faravelli C, Greenwald S, Hwu HG, Joyce PR, Karam EG, Lee CK, Lellouch J, Lepine JP, Newman SC, Oakley-Browne MA, Rubio-Stipec M, Wells JE, Wickramaratne PJ, Wittchen HU, Yeh EK. The cross-national epidemiology of panic disorder. Arch Gen Psychiatry. 54:305-9, 1997.

Wing JH, Nixon J, Mann SA, Leff JP: Reliability of the PSE (ninth edition) used in a population survey. Psychol Med 7:505-516, 1977

Wing JK, Babor T, Brugha T, Burke J, Cooper JE, Giel R, Jablensky A, Regier D, Sartorius N: SCAN: schedules for clinical assessment in neuropsychiatry. Archives of General Psychiatry, 47:589-593; 1990

Wittchen HU. Reliability and validity studies of the WHO--Composite International Diagnostic Interview (CIDI): a critical review. J Psychiatr Res 28:57-84, 1994

World Health Organization: Mental Disorders: Glossary and Guide to their Classification in Accordance with the Ninth Revision of the International Classification of Diseases. Geneva, World Health Organization, 1978

World Health Organization: The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva, World Health Organization, 1992

World Health Organization. The World Health Report 2001 Mental Health: New Understanding New Hope. Geneva: World Health Organization; 2001. Available at http://www.who.int/whr2001/

PSYCHOTHERAPY IN PSYCHIATRY RESIDENCY EDUCATION – YESTERDAY AND TODAY

Edward F. Foulks, M.D., Ph.D.

Tulane University
Health Sciences Center
School of Medicine

1430 Tulane Avenue SL 97
New Orleans, LA 70112
efoulks@tulane.edu

Despite recent attempts of conceptual integration, the cultural ethos and practice of psychiatry in the United States over the past 40 years has encountered profound transformations from mind to brain. This paper will address the confluence of demographic, economic, professional and scientific factors involved in these transformations.

While completing my training in general psychiatry in Philadelphia in 1964, I was encouraged by my faculty mentors to enroll in the psychoanalytic institute and to pursue a fellowship in child psychiatry in order to obtain a deeper appreciation of the childhood psychological developmental stages involved in pathological formations to be witnessed later in adult neurosis and psychosis. It was further evident to me that the residents in the upper ½ - a of the class were so encouraged and were generally eager to pursue the path of their mentors who were mostly psychoanalysts holding high academic positions – Departmental Chairs and Divisions Heads. During the fellowship in child psychiatry, child analysts supervised my treatment of autistic children using psychoanalytic play therapy. Prominent theories at that time emphasized "the refrigerator mother" and the "double-bind" as fostering the psychosis in these children.

Shortly after completing the child psychiatry fellowship, I was scheduled to take the oral board examination in psychiatry. Most of the examination focused on phobias of flying in airplanes. I was asked to speculate on the possible fantasies associated with such a phobia. I considered the then recent book entitled *"Coffee, Tea or Me"* and the possibility of conflicts over sexual issues. I was asked to speculate further. Pre-oedipal fantasies came to mind of the return to the womb-shaped plane, the enclosed – freely floating environment, the automatic supply of nourishment brought by a maternal hostess. I passed this exam!

Later as a faculty member in a department of psychiatry and a teaching psychoanalyst at a nearby Psychoanalytic Institute, I recall the conviction of the majority of psychoanalysts who argued that it was only the physician who was suited for psychoanalytic training and practice because of their experience witnessing and having responsibility with human birth, suffering and death. They felt that

those without medical training had only second hand, shallow appreciation of the angst and seriousness of human development and these biological realities.

The practice of psychiatry at that time was powerfully shaped by the models practiced in psychoanalysis. The 50-minute hour was standard for an appointment and inquiry followed psychodynamic formulations. "Neurotic" patients and some with "character disorders" comprised the majority of most practices.

Social, economic and scientific forces were already at work, however, that would create a rapid paradigm shift in psychiatric training and practice. The shift has been realized across the nation, and attributed by psychiatrists as well as by the public to the development of a host of new pharmaceuticals, whose effects could not only be witnessed through clinical examination but also directly by new functional brain imaging technology. These scientific breakthroughs indeed heralded a "Decade of the Brain", and even more.

The shift from sick "mind structures" to sick "brain structures" also occured in a cultural context which was primed to embrace, and further foster the change of paradigm. In 1988, a small group of parents with mentally ill offsprings met to form a new organization which they called the National Alliance for the Mentally Ill (NAMI).

NAMI's mission was to educate family members, consumers, and the general public and to advocate for reform for the care and treatment of those suffering from severe and persistent mental illnesses. Today NAMI has 250,000 members with a national office in Washington, DC, and affiliate offices in every state and large city. NAMI membership found itself in conflict initially with psychiatric practices which focused on the "refrigerator mother" or the "double-binding" parent. These theories lead to counseling that focused on and blamed bad parenting as a contributing cause for psychotic illness. Many were willing to take blame and tried to change, but witnessed no improvement in their relatives symptoms because of it.

NAMI therefore began to perceive "mind structure" theories as a continuity of and contributing to the stigma of mental illness. They recognized that inherent in the concept of mind is the platonic vision of the moral issues involved in the development of the cultivated, educated mind versus the primitive, disordered mind. When illness occurs, it is the victim and the family that are at fault, thus invoking stigma not unlike theories of moral weakness, possession by evil spirits or evil deeds such as masturbation. The shift away from illnesses of the "mind/soul" to illness of the "brain", (just like illnesses of any other organ of the body) is recognized by NAMI as reducing stigma. NAMI recognizes that stigma leads also to inferior – "carved out" treatment venues, lack of parity in health insurance, job and housing discrimination, and the criminalization and jails experienced instead of hospitals. NAMI advocates for appropriate medication; for supportive and rehabilitative therapies; and for the consumer and family members. The paradigm shift in psychiatry from "mind structures" to "brain structures" now aligns patient – family and doctor explanatory models of illness, which has improved therapeutic alliances.

Another factor driving the paradigm shift from "mind" to "brain" has been the ratio of psychiatrists to population numbers over the past 30 years. While the U.S. population has grown older and increased by 68 million people during that time, the number of new residents graduating

from programs during that period increased only slightly. It is fair to assume therefore that the number of potential patients with mental illness per psychiatrist is increasing. Increase in patient load necessitates reductions in time allocated to sessions as well as frequency of sessions. The managed-care psychiatric visit is infrequent (once per month) and short (15 minute) allowing only the "med check", and leaving no time for psychotherapy other than those manualized and prescribed like recipes of behavioral therapy. The limitations on program expansion to meet the needs of the aging and expanding population are to be found in Medicare DME/IME caps and VA-GME formulas. In the meantime, the ranks of psychologists, social workers, and other allied mental health professionals have increasingly taken up psychotherapy and counseling services, many partnering with psychiatrists who prescribe for their patients.

Psychoanalytic Institutes have therefore also transitioned from psychiatrists exclusively to a distinct majority of non-physician mental health professionals as well as liberal arts scholars.

The 2003 RRC Program Requirements for Residency Education in Psychiatry lists 30 objectives of training only one mentions:

> *"the major types of therapy, including short- and long-term individual psychotherapy, psychodynamic psychoterapy, family/couples therapy, group therapy, cognitive and behavior therapy, crisis intervention, drug and alcohol detoxification, pharmacological regimens, including concurrent use of medications and psychotherapy;"*[1]

In addition, tucked into 223 lines of RRC-Curriculum Requirements are 3 lines which mention:

> *"experience in both brief and long-term care of patients, using individual psychotherapy (including psychodynamic, cognitive, behavioral, supportive, brief) and biological treatment"*[2]

In a 2003 Report of the American Board of Psychiatry and Neurology on Core Competencies for Psychiatric Practice, Davis [3] cites a patient care competency that a certified psychiatrist must be able:

> *"A. To conduct therapeutic interviews, e.g., enhance the ability to collect and use clinically relevant material through the conduct of supportive interventions, exploratory interventions, and clarifications*
>
> *B. To conduct a range of individual, group, and family therapies, using standard, accepted models, and to integrate these psychotherapies in multimodal treatment, including biological and sociocultural interventions"*

Training and competencies in psychotherapy are therefore still expected in psychiatry programs, but the subject no longer occupies the dominant position it once held.

REFERENCES

[1] ACGME – *Graduate Medical Education Directory*, 2002-2003, AMA Press, Chicago, pp. 313

[2] ACGME – *Graduate Medical Education Directory*, 2002-2003, AMA Press, Chicago, pp. 314

[3] G. Davis, "General and Psychiatry-Specific Patient Care Core Competencies" in *Core Competencies for Psychiatric Practice*, Edited by S. Schreiber, T. Kramer, and S. Adamowski, API Press, Washington, DC, 2001, pp. 66

RELIGION AND SPIRITUALITY IN PSYCHIATRIC CARE

James K. Boehnlein, MD

Professor of Psychiatry
Oregon Health and Science University
Associate Director for Education
Veterans Administration Northwest Network Mental Illness Research, Education and Clinical Center (MIRECC)

P3MIRECC
3710 SW Veterans Hospital Drive
Portland, OR 97239
boehnlei@ohsu.edu

ABSTRACT

Psychiatry and religion both draw upon rich traditions of human thought and practice. In fact, psychiatry is the branch of medicine that most prominently incorporates the humanities and social sciences in its scientific base and it its treatment of illness. Both religion and psychiatry are concerned with how identity is defined and how this definition is affected by interpersonal and social processes. Only with the explosive growth of scientific knowledge in the 20th century have the roles of religious and medical healers become separate. This presentation will propose that psychiatry and religion are parallel and complementary frames of reference for understanding and describing the human experience and human behavior in the contemporary era. This has become increasingly important with the increased movement of the world's population, and the subsequent assimilation of a variety of belief systems and practices throughout the world. The author will highlight recent advances at the interface of psychiatry and religion in the areas of psychotherapy, research, clergy/psychiatry relationships, and psychological understanding of trauma and loss.

1. INTRODUCTION

The ways in which human beings attempt to understand the world, interact with it, and give meaning to their lives have occupied philosophers and scientists for centuries. In the contemporary era, the biological and social sciences and the humanities are frequently in conflict in their attempts to describe the natural world, human behavior, and the human conceptualizations of the universe. However, there is also a great deal of convergence among their concepts and constructs that often is obscured because such central elements of human existence inevitably are infused with ideological and political fervor.

Psychiatry and religion both draw upon rich traditions of human thought and practice. In fact, psychiatry is the branch of medicine that most prominently incorporates the humanities and social sciences in its scientific base and in its treatment of illness. And, in its attempts to explain the full range of human behavior, including behavior associated with mental illness, psychiatry has often needed to go well beyond the world of natural science into the philosophical realm.

In parallel fashion, all religions offer some type of explanation of how the universe was created, how life is maintained, and what happens when life ceases to exist. All religions attempt to give their followers explanations for life's meaning, including rationales for the reality of human suffering. Religious symbols, beliefs, myths, and rites enable individuals and groups to deal with the ultimate conditions of existence that are experienced by members of every society [1]. From the standpoint of the individual as part of a social unit, religion serves as a source of conceptions of the world, the self, and the relations between them [2]. Both religion and psychiatry are concerned with how identity is defined and how this definition is affected by interpersonal and social processes. And, for much of history, the separate functions of religious practice and healing were performed by a single individual in most world cultures. Only with the explosive growth of scientific knowledge in the 20th century have the roles of religious and medical healers become separate.

Psychiatry and religion can be parallel and complementary frames of reference for understanding and describing the human experience and human behavior. Although placing different degrees of emphasis on the relative importance of mind, body, and spirit in defining human nature, the objective and subjective perspectives of psychiatry and religion can be integrated in comprehensive patient care.

A discussion of psychiatry and religion is particularly timely now because of a resurgence of interest in religious belief and practice in many parts of the world, and because of the increased movement of the world's population, with the subsequent assimilation of a variety of belief systems and practices throughout the world. Mental health providers in developed countries increasingly are treating patients whose backgrounds are much different from their own, so it is important for them to understand cultural belief systems, including religious thought and practice, that relate to mental health and illness.

An increased awareness of religion in contemporary societies has both positive and negative aspects. From a positive point of view, religious belief systems may provide meaning for individuals or groups. Historically, religious organizations also have funded and operated mental health services in various countries, so it is important for organized psychiatry to be knowledgeable about the historical belief systems and political structures of these organized religions in order to coordinate services and have some influence on their effectiveness.

From a negative point of view, any religious fundamentalism, regardless of belief system, can be damaging not only to individual mental health and social adjustment but also to peaceful coexistence among cultures. Unfortunately, one can look across the globe to Northern Ireland, the

Balkans, Africa, and the Middle East for some prominent examples of how the politicalization of religious beliefs can destroy lives and cultures. This, too, is an important area for psychiatry, because survivors of regional war trauma can emigrate to other countries, where they subsequently attempt not only to acculturate but also to place their traumatic experiences into a meaningful context. How a mental health professional defines his or her identity and roles – for example, spouse, parent, colleague, or healer – may also be somewhat influenced by that individual's religious background and beliefs. It is important that practitioners be aware of these factors so that they can maintain proper boundaries between their personal and professional lives. Although psychiatrists, for example, are socialized to their role as healers during long years of medical education and training, their behavior also is influenced by social and cultural values that both precede and coexist with their professional life. Values and ways of thinking can be influenced by family background, peer interaction throughout the life span, and secular and religious education. An awareness of the influence of these diverse factors on identity and professional life is important for the practicing mental health professional. Contemporary decisions in mental health practice require clinicians to place their biomedical knowledge within a social and cultural matrix that has taken centuries to develop.

In fact, in the future psychiatrists will increasingly be required to confront numerous ethical and social policy issues with religious components, in addition to meeting patient demands for more comprehensive psychiatric approaches that incorporate spiritual perspectives.

I would like to illustrate some specific areas in psychiatric clinical care, education and research in which religion and spirituality will have increasing impact in the coming years. This is often in direct contrast to prior decades when these topics were generally ignored in psychiatry.

2. TRAUMA AND LOSS

The complex existential and spiritual issues associated with trauma and loss are central to both religious faith and the process of posttraumatic recovery. During and after traumatic events, individuals frequently report great cognitive dissonance between what they observe and experience in reality and what they previously believed were stable, secure, and predictable relationships, not only with other individuals but also with the supernatural or the metaphysical. The person recovering from the trauma does not have to be religious in a formal sense to experience this dissonance; how the person was socialized to reconcile the pain of loss is what is important [3]. Most importantly, including religious and spiritual perspectives in the clinical assessment of patients takes into account the effects of philosophical viewpoints, cultural values, and social attitudes on disease [4].

3. PSYCHOANALYSIS

Meissner [5] notes that one of the most significant contributors to the redirection of psychoanalytic thinking about religion was Erik Erikson, not only in his ingenious broadening of the scope of analytic concepts regarding personality development and the formations of identity, but also particularly in his interpretations of Luther [6] and Gandhi [7]. Meissner points out that Erikson was able to connect the most profoundly spiritual aspects of human experience with fundamental infantile roots and dynamics without entertaining the reductionistic fallacy that had plagued earlier efforts [8, 9]. Erikson wrote:

> But must we call it regression if man thus seeks again the earliest encounters of his trustful past in his efforts to reach a hoped-for and eternal future? Or do religions partake of man's ability, even as he regresses, to recover creatively? At their creative best, religions retrace our earliest inner experiences, giving tangible form to vague evils and reaching back to the earliest individual sources of trust; at the same time, they keep alive the common symbols of integrity distilled by the generations. If this is partial regression, it is a regression which, in retracing firmly established pathways, returns to the present amplified and clarified [6, p. 264].

4. PSYCHOTHERAPY

Johnson and Westermeyer [10] note that Marsha Linehan developed a therapy, Dialectical Behavioral Therapy (DBT), that she describes as an integration of two areas: her work in suicide prevention and behavior therapy and her experience as a Zen student of a Zen master and Benedictine monk [11, 12]. They point out that the main goals of Linehan's therapy are to enhance dialectical patterns of cognitive functioning and to change extreme behaviors to more balanced and integrated responses to the moment. DBT does not function on maintaining a stable, consistent environment, but instead aims to help the patient become comfortable with change. According to Linehan, the three main polarities of DBT are 1) the need for patients to accept themselves as they are and the need to change; 2) the tension between patients' getting what they need and losing what they need if they become more competent; and 3) patients' maintaining personal integrity versus learning new skills that will help them emerge from their suffering.

Johnson and Westermeyer also point out DBT's partial roots in Eastern religions by noting that Linehan has described dialectical thinking as the "middle path" between universalistic thinking and relativistic thinking. Dialectical thinking assumes that truth and order evolve and develop over time. Goals of this process consist of integrating contradictory points of view, learning to be comfortable with inconsistency, and avoiding simplistic explanations. This method is applied to patients with borderline personality disorder, who often have difficulty receiving new information and who tend to search unsuccessfully for absolute truths. Extremes and rigid behavior patterns are signals that a "middle way" has not been achieved.

5. CLERGY

Larsen, et al [13] describe a number of issues that are central to the relationships between psychiatrists and clergy that are important for patient care. Given a better understanding of the role and manifestations of religion in our culture, psychiatrists in the future will need to become increasingly sensitive to their patients' religious backgrounds and expressions. Psychiatrists will need to seek special knowledge about religious traditions that are unfamiliar to them. Such knowledge will help them to better identify the fine line between healthy religious expression and psychopathology. In many cases, mental health professionals will need to seek input from clergy familiar with the religious beliefs, practices, and experiences of members of these groups.

Clinicians and clergy share a number of qualities that have been universally identified as central to the efficacy of healers, including communicating the expectation that suffering will be relieved, conveying a knowledgeable manner, drawing together key individuals in the person's life, and generating hope for an improved existence [14]. In addition, one of the functions of a healer in psychiatric or religious practice is to help reestablish an equilibrium between a person and his or her

environment, whether that environment be the natural world, interpersonal relationships, or the person's struggle with meaning, beliefs, or values. Therefore, mental health practitioners and clergy may have separate yet complementary roles in restoring patients to health.

Larsen et al also note that many of the minor depressions, milder forms of major depression, mild to moderate anxiety, and minor adjustment and coping difficulties that plague a much larger proportion of the population can be handled quite well in the pastoral care setting [13]. Initial screening for the more severe psychiatric disorders should optimally occur at the religious community level to ensure early recognition and timely referral to psychiatric professionals; after diagnosis and treatment have been initiated by mental health professionals, clergy could assist in the follow-up of such patients by supporting the treatment plan, carefully monitoring for compliance, and observing the patient for disease exacerbations or flare-ups.

6. BIOETHICS

Religious perspectives are integral to most of the current dilemmas in psychiatric and biomedical ethics, including end-of-life decisions, physician-assisted suicide and euthanasia, abortion, and genetic research. In a multicultural society, the task of developing appropriate ethical guidelines in biomedicine is fraught with great challenges, opportunities, and controversy. Professional ethics cannot be judged in isolation from society's broader ethical traditions, which are influenced by both secular and religious values. With the increasing medicalization of social issues, many physicians are forced to examine their own ethical beliefs. In order to deal with contemporary ethical issues, psychiatrists must be able to draw upon a broadly based intellectual tradition, not only in the biological sciences but also in the humanities and social sciences, which includes the comparative study of religion.

7. FUTURE RESEARCH

Studies have shown that many, if not most, Americans use religion to help them cope, particularly during times of acute stress [15]. Koenig [16] notes that further studies are necessary to compare the effects of religious coping with those of nonreligious coping behaviors (e.g., distracting activities, support from family) on mental health and emotional well-being. Although recent research has emphasized the health-promoting effects of devout religiousness, relatively few investigations have attempted to identify the specific elements of religious coping that are beneficial – or to isolate types of religious coping that are detrimental to health, as has been suggested by some earlier investigators [17, 18, 19]. Koenig also nicely summarizes cautions that should be considered in this area. Certain religious groups may exert a control over their members that is almost hypnotic in its extent, so that members' free will is jeopardized. Likewise, rigid, narrow thinking and intolerance of other opinions or views may foster maladaptive, inflexible coping practices. On the other hand, groups emphasizing religious teachings that promote compassion, forgiveness, altruism, positive thinking, and healthy behaviors may foster adaptive coping practices. These aspects of religious belief and practice must be subjected to careful systematic study.

Koenig further notes that, with a few exceptions, [20, 21, 22], most research examining the relationship between religiousness and mental health has been cross-sectional. Although cross-sectional studies provide information about *association*, they do not elucidate causality or direction of effect. Longitudinal, prospective studies or clinical trials are necessary to yield information about the time sequence of events.

There is certainly a great deal of promise for the future relationships between psychiatry and religion in patient care, education, and research.

REFERENCES

[1] W DeCraemer, J Vansina, RC Fox, "Religious movements in central Africa," *Comp Stud Soc Hist*, 18:458-475, 1976.

[2] C Geertz, *The Interpretation of Cultures*, New York: Basic Books, 1973.

[3] M Eisenbruch, "Cross-cultural aspects of bereavement, I: a conceptual framework for comparative analysis," *Cult Med Psychiatry*, 8: 283-309, 1984.

[4] H Fabrega, "The need for an ethnomedical science," *Science*, 198:969-975, 1975.

[5] WW Meissner, "Psychoanalysis and Religion: Current Perspectives," in *Psychiatry and Religion: the Convergence of Mind and Spirit*, ed. JK Boehnlein, Washington DC: American Psychiatric Press, 2000.

[6] EH Erikson, *Young Man Luther: A Study in Psychoanalysis and History (1958)*, New York: WW Norton, 1962.

[7] EH Erikson, *Ghandi's Truth: On the Origins of Militant Nonviolence*, New York: WW Norton, 1969.

[8] WW Meissner, *Life and Faith: Psychological Perspectives on Religious Experience*, Washington, DC: Georgetown University Press, 1987.

[9] H Zock, *A Psychology of Ultimate Concern: Erik H. Erikson's Contribution to the Psychology of Religion (International Series in the Psychology of Religion)*, Atlanta, GA: Editions Rodopi, 1990.

[10] DR Johnson and J Westermeyer, "Psychiatric Therapies Influenced by Religious Movements," in *Psychiatry and Religion: the Convergence of Mind and Spirit*, ed. JK Boehnlein, Washington DC: American Psychiatric Press, 2000.

[11] MM Linehan, *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, New York: Guilford, 1993.

[12] MM Linehan, *Skills Training Manual for Treating Borderline Personality Disorder*, New York: Guilford, 1993.

[13] DB Larsen, et al, "The Role of Clergy in Mental Health Care," in *Psychiatry and Religion: the Convergence of Mind and Spirit*, ed. JK Boehnlein, Washington DC: American Psychiatric Press, 2000.

[14] JD Frank, *Persuasion and Healing*, Baltimore, MD: Johns Hopkins University Press, 1961.

[15] HG Koenig, "Faith and spirituality as a means of coping with stress," *Theology News and Notes*, 42: 6-8, 22, 1995.

[16] HG Koenig, "Religion and Future Psychiatric Nosology and Treatment," in *Psychiatry and Religion: the Convergence of Mind and Spirit*, ed. JK Boehnlein, Washington DC: American Psychiatric Press, 2000.

[17] M Rokeach, *The Open and Closed Mind*, New York: Basic Books, 1960.

[18] L Salzman, "The psychology of religious ideological conversion, *Psychiatry*, 16: 177-187, 1953.

[19] VD Sanua, "Religion, mental health, and personality," *Am J Psychiatry*, 125: 1203-1213, 1969.

[20] DG Blazer, E Palmore, "Religion and aging in a longitudinal panel," *Gerontologist*, 16:82-85, 1976.

[21] EL Idler, SV Kasl, "Religion, disability, depression, and the timing of death," *Am J Sociol*, 97: 1052-1079, 1992.

[22] HG Koenig, HJ Cohen, DG Blazer, et al, "Religious coping and depression in elderly hospitalized medically ill men," *Am J Psychiatry*, 149: 1693-1700, 1992.

Tortured and Traumatized Somali and Ethiopian Refugees in Minnesota: Reactions to 9/11 and Subsequent Retraumatizing Events

James M. Jaranson, M.D., M.A., M.P.H.

Division of Epidemiology, School of Public Health, and
Department of Psychiatry, School of Medicine, University of Minnesota;
Division of Behavioral Health, Regions Hospital, St. Paul, MN
Mailing Address: 1666 Coffman, #224, St. Paul, MN 55108
Email Address: jaran001@umn.edu

Cheryl Robertson, Ph.D., M.P.H., R.N.

School of Nursing, University of Minnesota

Marline Spring, Ph.D.

Division of Epidemiology, School of Public Health, University of Minnesota

Joseph Westermeyer, M.D., M.P.H., Ph.D.

Department of Psychiatry, University of Minnesota at VAMC

James Butcher, Ph.D.

Department of Psychology, University of Minnesota

Linda Halcon, Ph.D., M.P.H., R.N.

School of Nursing and Division of Epidemiology, University of Minnesota

David Robert Johnson, M.D., M.P.H.

Department of Psychiatry, University of Minnesota at VAMC;
Center for Victims of Torture, Minneapolis

Kay Savik, M.S.

School of Nursing, University of Minnesota

ABSTRACT

The Refugee Population Study (RPS) at the University of Minnesota, funded by U.S. National Institute of Mental Health (NIMH) for five years, completed a representative sample of 1,134 participants from the Somali and Ethiopian (Oromo) communities in the Twin Cites metropolitan area shortly before 9/11. After 9/11, many participants in the RPS study were reluctant to be interviewed again for the second and third phases, despite familiarity with RPS and knowing the ethnic interviewers.

When the rate of interviewing increased, we added 23 questions to the remaining questionnaires in an attempt to elucidate the reasons for such reluctance to cooperate with our project. The 23 questions were based on an instrument developed by the Office of Behavioral and Social Science Research (OBSSR) to measure the impact of 9/11. Three scales, Composite, Trauma, and Stress, were developed from these questions.

As expected, Muslims were more adversely affected by 9/11 than Christians, and distress scores decreased over time. All three 9/11 scales correlated with increased social problems, and two scales with high overall past trauma experience. Unexpectedly, there were no differences between tortured and non-tortured participants on any of the scales. Oromo men, who had experienced the most torture, scored lower on the 9/11 scales.

We found that 54% of the 131 participants surveyed were more pessimistic about their future, while 39% were worried about their immigration status and had less faith in the ability of the government to protect them. More than 70% sought help from family, and only 8% stated they needed no help at all.

1. BACKGROUND OF THE RESEARCH PROJECT

Historically, refugees and asylum seekers have a high probability of experiencing politically-motivated torture [1]. The U.S. has resettled many groups of refugees, including the predominantly (85%) Muslim populations from Somalia and Ethiopia surveyed by our research project. With civil war and lack of formal government for more than a decade [2], Somalis have often suffered traumatic experiences. Oromos have claimed ongoing political oppression ever since their territory was incorporated into the country of Ethiopia at the end of the 19th century [3-5].

The sensitivity of torture makes it difficult to study, and refugees are challenging groups for research [6]. Between 5% and 35% of refugees have been tortured according to the most frequently cited review [7]. Existing studies of torture and associated factors have typically been conducted in refugee clinics and in other treatment settings [1, 6, 8-16], suggesting that posttraumatic stress, anxiety, depression, and somatization are common [17, 18]. Any consequences specifically associated with torture, compared with other traumatic events which refugees commonly experience, still need to be identified and the effects quantified [19, 20].

Our five-year, multi-phased, community-based, epidemiological study, the Refugee Population Study (RPS), funded by the U.S. National Institute of Mental Health (NIMH), was the largest epidemiological survey of resettled refugees in the Western world [21]. We aimed to identify demographic characteristics, pre- and post-migration factors, torture prevalence, and the association of torture survival with health and social problems in two resettled refugee communities, Somalis and Oromos in the Twin Cities of Minneapolis and St. Paul, Minnesota U.S.A.

In the first phase, we surveyed a representative sample of 1,134 adult members of these two East African communities to determine a prevalence of torture and associated social and health problems, including posttraumatic stress. Scales were developed to assess social problems, physical problems, and psychological problems [21]. In addition, posttraumatic stress symptoms were scored using the Posttraumatic Checklist (PCL-C). Two subsequent surveys of subsets from this sample compared torture survivors with non-tortured refugees using: 1) structured instruments to assess symptoms, disability, coping, social support, and family function and 2) a brief neurological screen to identify soft signs of impairment and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) [22] to make DSM-IV and ICD-10 psychiatric diagnoses.

2. INTERVIEWING FOLLOWING SEPTEMBER 11, 2001 (9/11)

Immediately following the terrorist attacks on New York City and Washington, D.C., on September 11, 2001, interviewing for the project virtually stopped. For several months, participants frequently were either reluctant to be interviewed again or refused. This was despite the fact that the second and third quantitative interview phases were subsets from the initial sample, and participants knew their ethnic interviewers from the first interviews.

In addition to any reactions to 9/11, several events in the Twin Cities during the months after 9/11 may have compounded the fear and mistrust of many Muslims: 1) Shortly after 9/11, Somalis reported harassment by local residents; 2) In October, an elderly Somali man was killed on a Minneapolis street in a presumed hate crime; 3) In November, five money transfer businesses, used by refugees to send funds to relatives in Africa, were closed by the FBI, which suspected that the funds were used to support terrorist organizations; 4) In December, the FBI increased questioning of young African men; 5) In January, 2002, Somalis protested the release of the film “Black Hawk Down,” which they felt was inaccurate and demeaned them; 6) In February, ten young Somali men were deported to Mogadishu and at least one of them was subsequently killed on the city streets; 7) In March, police killed a mentally ill Somali man who they claimed was brandishing a machete; 8) In

September, the FBI suspected an al-Qaeda cell in Minneapolis and increased their interrogation of local Muslim men. These incidents, which were extensive publicized by the news media, made for a potentially uncomfortable environment for the refugee communities we were surveying.

Since the participation rate was >97% of those selected for interview in the initial phase, we became concerned when many participants refused additional interview requests. We did not know whether this was coincidentally related to 9/11, whether participants were distressed or distrustful following 9/11, or whether they were refusing because of interview fatigue or dissatisfaction with the RPS. In order to assess participant reactions to 9/11, we added 23 questions to the remaining interviews in our final two surveys. The final results of these 131 interviews are presented here.

3. REVIEW OF THE LITERATURE STUDYING THE EFFECTS OF 9/11

Although a number of studies were conducted following 9/11, the methods employed were not likely to have adequately surveyed immigrants and refugees, among the most vulnerable population groups in the U.S. Kinzie et al. [23] questioned many of the more than 900 Bosnian, Somali, and Southeast Asian refugees treated in their international clinic in Oregon, finding that 47% of Somalis and 75% of Bosnians, who are predominantly Muslim, were the most fearful. Somalis had the greatest decrease in a sense of security since 9/11. Patients with posttraumatic stress disorder (PTSD) and depression had the most intense responses, which returned to baseline within one to two months. However, unlike the RPS, Kinzie et al. sampled patients in treatment, who may not necessarily represent their refugee communities.

Other studies surveyed mainstream populations in the U.S. using methodologies that were unlikely to adequately sample refugees: 1) random digit telephone dialing (Schuster et al. [24]; Melnik et al. [25] and 2) web-based surveys (Schlenger et al. [26]; Silver et al. [27]). Refugees are less likely to have either telephones or computers than the mainstream population and, consequently, would most likely be underrepresented in these surveys.

Schuster et al. surveyed the U.S. population 3-5 days post-9/11 and found that 44% of respondents reported significant stress, and 47% were worried about their own safety. Melnik et al. surveyed New York and the nearby states of Connecticut and New Jersey one to three months after the attack. They found that 75% had “problems” and that 50% were very angry about the attacks. Schlenger et al. surveyed the entire U.S., but purposefully oversampled New York and Washington, D.C. They found that, at one to two months, 4% of the U.S. population surveyed had symptoms consistent with PTSD, but those surveyed in New York and Washington, D.C., had higher rates. Silver et al. surveyed only the U.S. outside of New York City, finding a 17% prevalence rate of PTSD two months after 9/11 and the decreased rate of 6% upon re-evaluation six months after 9/11.

4. OBJECTIVES

We had a two-fold objective for assessing the reactions to 9/11 of our predominantly Muslim Somali and Ethiopian Oromo participants: 1) By eliciting the specific reasons for reluctance to participate, we hoped to increase participation and complete our study; 2) Immigrants and refugees, among the most vulnerable population groups in the U.S., were not systematically surveyed following 9/11. Assessing our participants’ reactions to 9/11 could contribute to a better understanding of these communities.

5. METHODS

When participants agreed to be interviewed again, we added 23 questions to the remaining interviews to assess the reactions of participants following 9/11 (Appendix 1). These questions were

based on the Office of Behavioral and Social Science Research (OBSSR) Instrument for Measuring Impact of 9/11 and measured how participants view themselves, other people, and the world in general. The 9/11 questionnaires, in conjunction with our final interview surveys, were completed in April, 2003.

We hypothesized that 1) torture survivors from our prevalence sample would suffer more after 9/11 than the refugees who were not tortured but were traumatized in other ways; 2) Oromo men, who were most often tortured (69%) in our initial prevalence survey, would suffer more than either Oromo women (torture prevalence 37%) or Somali women (torture prevalence 47%). (Somali men, who had completed all interview phases prior to 9/11, had a torture prevalence rate of 25%).

The 23 questions were combined into three 9/11 scales (Appendix 1): 1) the Composite Scale, consisting of the first 13 Likert-scored items; 2) the Trauma Scale, comprised of the next six items (14-19) and requiring a "yes" or "no" response, and 3) the Stress Scale, based on the participant's response to Question 23 (how stressful life had been since 9/11), rated on a scale of one to ten, with ten the most stressful.

The 9/11 Composite Scale was analyzed using ANOVA or t-test. The Trauma and Stress Scales were analyzed using Kruskal-Wallis ANOVA or Mann-Whitney U test.

6. RESULTS

Questionnaires were completed by 131 participants. Since the interviews for all three interview phases had been completed for Somali men, we had only three groups of ethnic/gender respondents: Somali women (N=35), Oromo women (N=37), and Oromo men (N =59). Nine Somali women refused to participate, but all Oromos agreed.

Questionnaires were administered a median of 15.3 months following 9/11 (range 4.75 to 18.8 months). The more time that elapsed between 9/11 and the administration of the 9/11 Questionnaire, the lower the Composite ($p=.02$) and Trauma ($p=.002$) Scale scores but not the Stress Scale scores.

For the Composite Scale, Oromo men had lower scores than either Oromo or Somali women ($p<.001$). On the Trauma Scale, Oromo men had lower scores than Oromo women ($p<.01$) but not Somali women. On the Stress Scale, Oromo men once again had significantly lower scores than either group of women ($p<.001$).

Muslim respondents had significantly higher Composite Scale scores ($p=.035$) and Stress Scale scores ($p=.025$) than Christians, but not Trauma Scale scores.

Comparisons with results of the sample (N=1,134) from the initial prevalence survey were made. From the responses to the first survey, scales to assess social, physical, and psychological problems, including posttraumatic stress, were developed. All three 9/11 Scales correlated significantly with the higher scores on the social problems scale. Only the Composite Scale correlated with higher scores on the psychological problems scale. The Composite Scale correlated with the hyperarousal subscale of the PCL-C, but not the avoidance or intrusive subscales. The Composite and Trauma Scales correlated with an increased overall trauma count for the prevalence sample.

P-values comparing 9/11 questionnaire respondents based upon their classification as tortured or not-tortured in the prevalence survey showed no significant difference on any of the 9/11 Scales (Composite $p=.27$, Trauma $p=.28$, Stress=.61). Torture survivors were no more likely to experience posttraumatic stress symptoms or to have higher scores on the physical or psychological problem scales.

Examples of individual item responses endorsed "very true" or "extremely true" on the Composite Scale included 54% feeling more pessimistic about their future well-being (Item 2), 44% more fearful for their own safety because of religion or ethnicity (Item 13), 42% less safe (Item 1),

and 39% more worried about their immigration status (Item 11). Among respondents, 39% had decreased belief that they could solve their own problems (Item 4) and 32% had decreased faith that the U.S. government would protect them (Item 3).

Sources of help for distress included family (70%), other Somalis or Oromos (45%), and other Americans (10%), while 8% said they needed no help.

7. DISCUSSION/CONCLUSIONS

Using a 9/11 Questionnaire, our study surveyed the responses of participants from two refugee communities, which makes it a unique contribution to the epidemiological literature. These resettled East African refugees, especially Muslims, have suffered since 9/11, although it is difficult to compare published studies with our results. Our study highlights the ways in which these respondents have suffered, which makes it more understandable why we had such a difficult time recruiting participants to complete our research following 9/11. A high percentage of respondents felt unsafe, unsure of themselves, and otherwise vulnerable. Those who were identified as highly traumatized in the initial survey also had high Composite and Trauma Scale scores in the 9/11 survey, indicating that they were at higher risk for retraumatization.

Somali women frequently refused to answer the 9/11 questions. Anecdotally, Somali women told the interviewers that they wanted to be apolitical because politics had brought them nothing but trouble. Unfortunately, Somali men were not part of our 9/11 survey, and we cannot extrapolate the findings from Somali women to Somali men. The sample size for the remaining three ethnic/gender groups was relatively small, which makes generalizability to the study populations preliminary.

We hypothesized that Oromo men would suffer more because they had more frequently experienced past torture. It is still possible that they did suffer more, despite their lower scores than women on the 9/11 Scales. The idiom of distress for men and women may well differ. In addition, Muslim women, with their distinctive dress, are much more easily identified than Muslim men.

Surprisingly, torture survivors appeared to suffer no more than those who were not tortured, albeit also traumatized. It would appear that 9/11 affected our refugee respondents adversely, including those who had been spared the experience of torture.

As Kinzie et al. found in their clinic sample and, as many studies in the posttraumatic stress literature note, symptoms decrease over time. This was also true in our study.

As expected, Muslim respondents were adversely affected by 9/11 more often than Christians, since Muslims would presumably more often be suspected as terrorists or terrorist sympathizers.

The vast majority of RPS participants we surveyed have not accessed Western-based mental health services. Less than 1% of the initial prevalence participants either accepted or followed up with a referral to Western services, even though many more were identified as needing help. In addition, the findings of this 9/11 questionnaire emphasize the need to attend to the additional effects of retraumatizing events when identifying those in need.

REFERENCES

1. JM Jaranson. The science and politics of rehabilitating torture survivors: An overview. In: Jaranson JM, Popkin, MK., editors. *Caring for victims of torture*. Washington, DC: American Psychiatric Press; 1998. p.15-40.
2. Putman DB, Noor MC. *The Somalis: Their history and culture.* Washington, DC: The Refugee Service Center, Center for Applied Linguistics; 1993. CAL Refugee Fact Sheet #9.
3. Trueman T. Genocide against the Oromo people of Ethiopia?: Western influence; 2001.
4. Economist Intelligence Unit. *Country profile: Ethiopia, Eritrea, Somalia, Djibouti*. Economist Intelligence Unit; 1994-95.
5. US State Department. *Annual Human Rights Reports, 1997.* Washington DC: U.S. State Department: Bureau of Democracy, Human Rights and Labor; 1998.
6. Basoglu M, Jaranson JM, Mollica R, Kastrup M. Torture and mental health: A research overview. In: Gerrity E, Keane TM, Tuma F, editors. *The mental health consequences of torture*. New York: Kluwer Academic/Plenum Publishers; 2001. p. 35-62.
7. Baker R. Psychological consequences for tortured refugees seeking asylum and refugee status in Europe. In: Basoglu M, editor. *Torture and its consequences: Current treatment approaches*. Cambridge: Cambridge University Press; 1992. p. 83-101.
8. Jaranson JM, Kinzie JD, Friedman M, et al. Assessment, diagnosis, and intervention. In: Gerrity E, Keane TM, Tuma F, editors. *The mental health consequences of torture*. New York: Kluwer Academic/Plenum Publishers; 2001. p. 249-75.
9. Jaranson JM, Martin SF, Ekblad S. Refugee mental health: Issues for the new millennium. In: Manderscheid RW, Henderson MJ, editors. *Mental health, United States, 2000*. Rockville, Maryland: US Department of Health and Human Services; 2001. p. 120-33.
10. Jaranson JM, Popkin MK, editors. *Caring for victims of torture*. Washington, DC: American Psychiatric Press; 1998.
11. Basoglu M, editor. *Torture and its consequences: Current treatment approaches*. Cambridge, England: Cambridge University Press; 1992.
12. Lavik NJ, Hauff E, Skrondal A, et al. Mental disorder among refugees and the impact of persecution and exile: Some findings from an out-patient population. *Br J Psychiatry* 1996;169:726-32.
13. Moore LJ, Boehlein JK. Posttraumatic stress disorder, depression, and somatic symptoms in U.S. Mien patients. *J Nerv Ment Dis* 1991;179:728-33.
14. Boehnlein JK, Kinzie JD. Refugee trauma. *Transcultural Psychiatric Research Review* 1995;32:223-52.
15. Mollica RF, Wyshak G, Lavelle J. The psychosocial impact of war trauma and torture on Southeast Asian refugees. *Am J Psychiatry* 1987;144(12):1567-72.
16. Ekblad S, Roth G. Diagnosing posttraumatic stress disorder in multicultural patients in a Stockholm psychiatric clinic. *J Nerv Ment Dis* 1997;185:102-7.
17. Westermeyer J, Bouafuely M, Neider J, et al. Somatization among refugees: An epidemiological study. *Psychosomatics* 1989;30:34-43.
18. Beiser M, Fleming JA. Measuring psychiatric disorder among Southeast Asian refugees. *Psychol Med* 1986;16:627-39.
19. Silove D, Steel Z, McGorry P, et al. The impact of torture on post-traumatic stress symptoms in war-affected Tamil refugees and immigrants. *Compr Psychiatry* 2002;43(1):49-55.
20. Steel Z, Silove D, Bird K, et al. Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees, and immigrants. *J Trauma Stress* 1999;12(3):421-435.
21. Jaranson J, Butcher J, Halcón LL, et al. Somali and Oromo refugees: Correlates of torture and trauma. *Am J Public Health* (accepted) 2003.
22. Wing JK, Babor T, Brugha T, et al. SCAN: Schedules for Clinical Assessment in Neuropsychiatry. *Arch Gen Psych.* 1990;47:589-93.
23. Kinzie JD, Boehnlein, JK, Riley C, Sparr L. The effects of September 11 on traumatized refugees: Reactivation of posttraumatic stress disorder. *J Nerv Men Dis* 2002;190:437-41.
24. Schuster MA, Stein BD, Jaycox LH, et al. A national survey of stress reactions after the September 11, 2001, terrorist attacks. *N Engl J Med* 2001;345(20):1507-12.
25. Melnick TA, Baker CT, Adams ML, et al. Psychological and emotional effects of the September 11 attacks on the World Trade Center—Connecticut, New Jersey, and New York, 2001. *Morbidity and Mortality Weekly Report* 2002;51(35):784-6.

26. Schlenger WE, Caddell IM, Ebert L, et al. Psychological reactions to terrorist attacks: Findings from the nationa study of Americans' reactions to September 11. J*AMA* 2002;288(5):581-8.

27. Silver, RC, Holman, EA, McIntosh, DN, Poulin, M, Gil-Rivas, V. Nationwide longitudinal study of psychological responses to September 11. *JAMA* 2002;288(10): 1235-44.

APPENDIX 1: 9/11 QUESTIONS AND SCALES

COMPOSITE SCALE:
Questions 1 – 13 are asked using the following Likert scale:
Not at all true (1) A little true (2) Somewhat true (3) Very true (4) Extremely true (5)

Major events like the 9/11 attack can change the way people view themselves, other people, or the world in general. How true are the following statements about you?
1. You feel less safe than you did before the disaster on September 11. Is this...
2. You feel more pessimistic about your own future well-being.
3. You have less faith in government's ability to protect you than you did before the disaster.
4. You have less belief in yourself to solve your problems.
5. You do your work, school, or other important tasks less carefully since the 9/11 attack.
6. You do your regular daily activities less carefully now (e.g., cooking, paying bills, doing laundry, making coffee, cleaning the house, etc.).
7. You spend less time with other people such as friends and family.
8. You spend less time doing outside activities (e.g., going to religious services, visiting friends or relatives, attending cultural events, playing sports, going to parties or other special functions)?
9. You have had trouble sending money to people in Africa because the money transfer places were closed.
10. You have been distressed by increased requests for money from people in Somalia, Oromia, or Kenya.
11. Even though you have done nothing wrong, you worry that your immigration status will be adversely affected.
12. You feel less accepted by other Americans.
13. You have more fear for your safety and well-being because of you ethnicity or religion.

TRAUMA SCALE:
14. Have you been harassed verbally? Y/N
15. Has anyone threaten to harm you physically? Y/N
16. Has anyone actually harmed you physically? Y/N
17. Have you changed your normal activities because of your fear? Y/N
18. Have your relatives or neighbors been harmed physically? Y/N
19. Has your property been vandalized? Y/N

QUESTIONS NOT INCLUDED IN SCALES:
20. Were you laid off from your job as a result of the 9/11 attack or subsequent events? Y/N
If yes, was it for : Less than 1 month? More than 1 month?
21. Was any other person in your family been laid off from his/her job as a result of the 9/11 attack and the subsequent events? Y/N If yes, was it for: Less than 1 month? More than 1 month?
22. For problems since the 9/11 attack, did you get help from: (check all that apply):
Family members, Other members of the Somali or Oromo communities, Other Americans, No problems

STRESS SCALE:
23. Overall, considering both big ways and little ways that you were touched by the events of September 11, how stressful would you say your life has been since. Please answer this question on a scale from 1 to 10, where 1 means that you have not personally been stressed or distressed at all, and 10 means that you have been terribly or extremely stressed or distressed
Not stressed 1 2 3 4 5 6 7 8 9 10 Extremely stressed

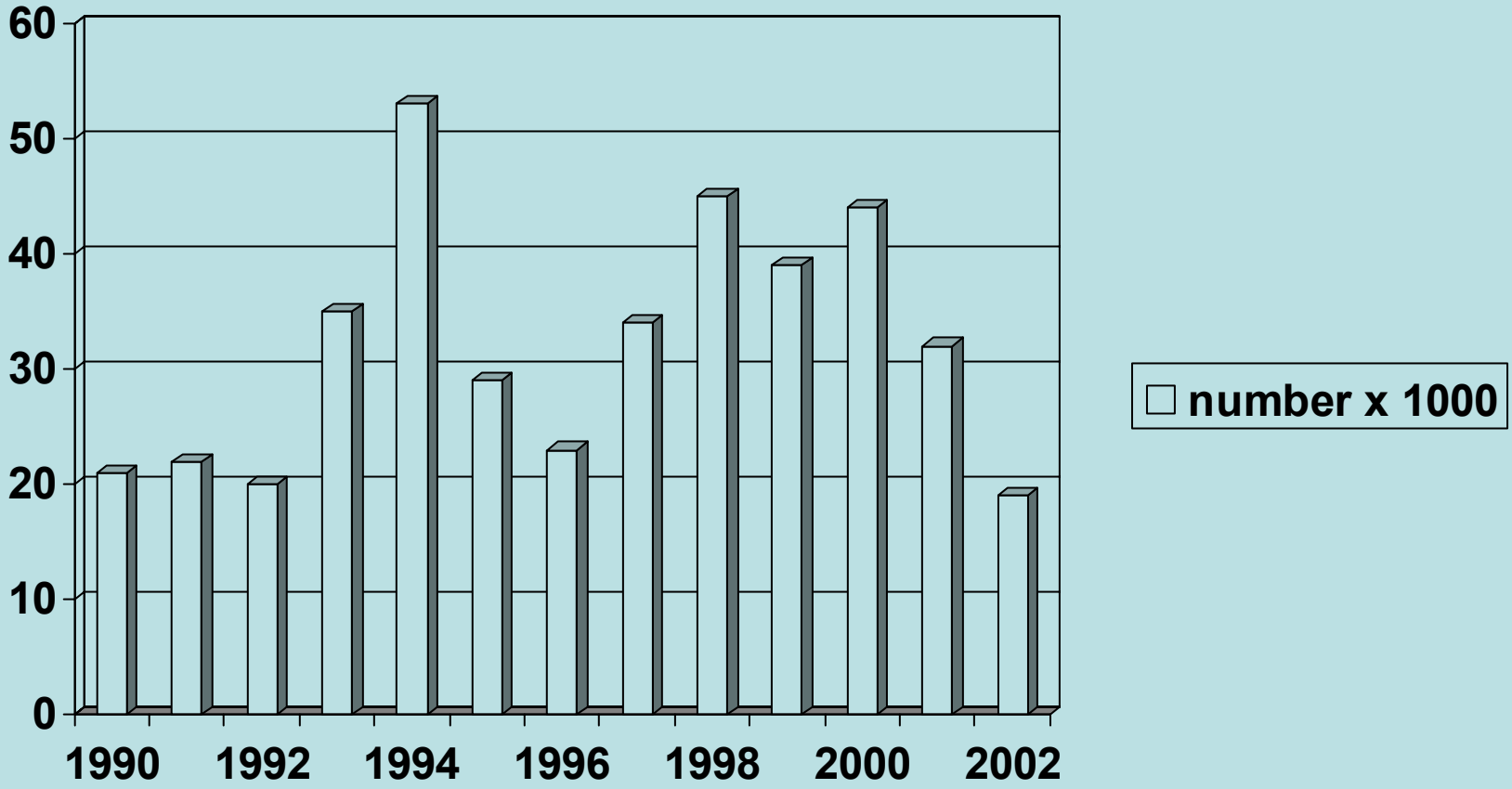
Mental Health Care Programs for Refugees

Johannes G.B.M.Rohlof, M.D.
Centrum '45- de Vonk
the Netherlands

Situation in the Netherlands

- Large influx of refugees in 1994 (Bosnian war) and in the late 90s (refugees from Afghanistan and Iraq)
- Decrease in 2001 and 2002 because of ending wars and stricter admission rules
- Large number of settled refugees with permit stay or naturalization (possible after five years of legal stay)

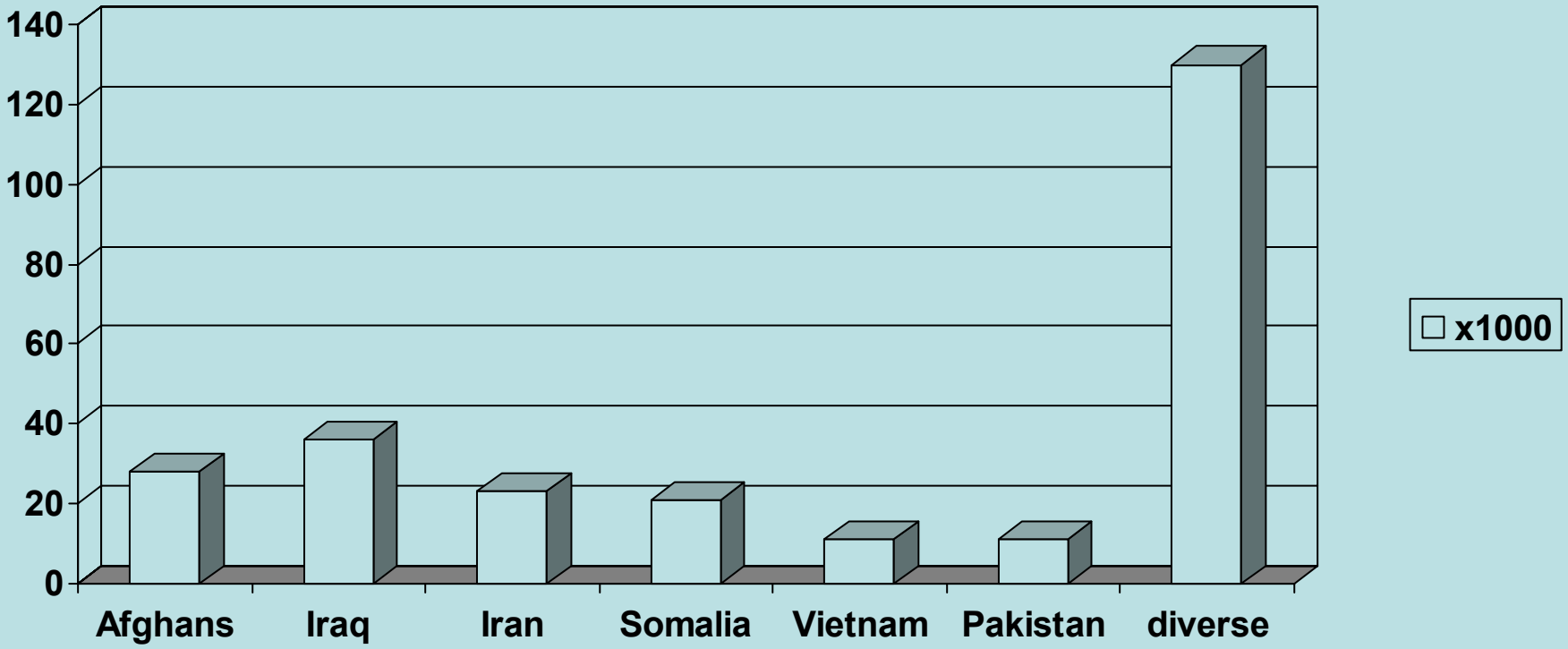
Numbers of incoming refugees



Number of nonwestern citizens rising in the Netherlands (numbers of 1.1.2002)

- Total population: 15,5 million
- Total born outside the Netherlands: 1,55 million
- Total born in nonwestern country: 972.000
- Total children born in the Netherlands of nonwestern parents: 587.000

Numbers of some nonwestern ethnic groups (1.1.2002)



Epidemiology of psychiatric disease in refugees

- Kosovars: 50 % PTSD (Turner, 2003)
- Afghans: 57 % depression, 35 % PTSD (Gernaat, 2002)
- Iraqi: depression in 41 % of males, 61 % of females, PTSD in 40 % of males, 57 % of females (Laban, 2002)

Mental Health Care in the Netherlands

- regional care provided in all regions
- outpatient and inpatient care in most regions integrated in same institution
- general insurance provide in mental health care for all citizens
- psychiatric care available in all cities and smaller towns, within 30 km.

Health Care Provision for Refugees

- Refugees with permit to stay have same access as Netherlands citizens
- Refugees with asylum seeker status have special insurance
- Asylum seeker insurance provides in all medical treatments, except for treatment like IVF, cosmetic plastic surgery and so on.

Health Care Provision for Refugees (2)

- Insurance for asylum seekers provides in specialized care in two national centers ('last resort care')
- Medical urgent care for illegal persons can be paid for by fund for illegal persons, with certain limitations

Refugee Mental Health Care in Regular Services

- Programs for special groups, for instance group therapy for ethnic groups
- Day clinic treatment in several regional centers: different programs, mostly consisting in trauma treatment in a transcultural setting (testimony in groups, family treatment, ritualistic treatment)

Two National Centers

- Phoenix: clinic for specialized psychiatric care for refugees
- Centrum '45: clinic, day clinic and outpatient departments for trauma treatment with refugees

Three axes of treatment

- Acculturation
- Trauma treatment
- Self care

Acculturation

- Psychoeducation about disease and treatment (including video instruction)
- Learning to cope with western communication styles (including video instruction)
- Learning to cope with discrimination (awareness about own image, behavior)
- Learning to cope with stigmatization

Mental Health Care Programs for
Refugees. J.Rohlof, nov 2003

Acculturation

- Cultural interview in some cases:
- Structured interview with 40 open questions
- More information about cultural background

Trauma treatment

- Individual treatment: testimony method as cultural sensitive treatment
- Treatment follows steps of the patient, no standard treatment steps
- Group treatment focuses on building trust and confidence, not at expression of traumatic experiences
- Gender groups give more disclosure

Self care

- Nonverbal Therapies: learning to cope with materials, learning to cope with sounds, learning to cope with bodily sensations.
- Psychohygiene: learning to balance with stress and relaxation, with attention and withdrawal

Outcome (1)

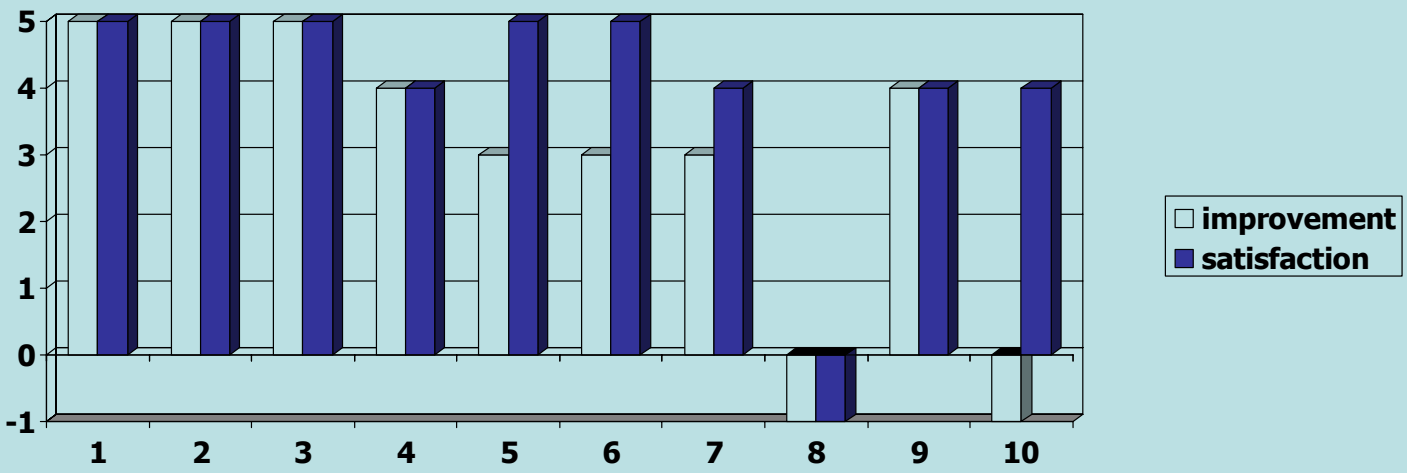
- Impression staff members: overall favorable effects.
- Sometimes prevalence of asylum problems.
- Complaints diminish but do not disappear. Nightmares for instance difficult to treat.
- Hard or impossible to state effect of modes of treatment

Outcome (2)

- Systematic gathering exit data
- Exit interview with 52 questions
- Comparing Harvard Trauma Questionnaire and Hopkins Symptoms Checklist before and after treatment
- Few data available

Outcome (3)

- 10 exit interviews day clinical patients
- 6 male, 4 female
- Age 20-53 years



Outcome (4)

- Comments:
- I cannot find words for my gratitude.
- Lunch together is important. Day schedule should be less strict.
- Not enough attention for culture. PMT important.
- Identification in group important, but sometimes difficult.
- Got treatment for my illness, not my problems.
- More rest in my head.
- Problems with Dutch language, but satisfied.
- Unsafe in the group.
- Contact with therapists good, but less with other patients.
- Less complaints. Satisfied about staff.

More information

- www.centrum45.nl
- www.rohlof.nl

SEEKING ASYLUM, ACCUMULATING STRESS

Rolf V.Schwarz, psychiatrist, MD PhD;
Marjan C.M.Mensinga, MSc

de Geestgronden/Symfora Groep/Pharos

POBox 16
1180 AA Amstelveen
The Netherlands
r.schwarz@geestgronden.n

ABSTRACT

Since the late eighties a steady flow of asylum seekers from non-western countries has come to the Netherlands. This stream reached its peak in 1998, when 45,000 people asked for asylum. From 2001 onwards, probably due to the introduction of stern measures by the Dutch government the numbers decreased. In the first six months of 2002 11,000 refugees declared themselves to the Dutch authorities.
In the middle of the nineties, when the accumulative number of people waiting for a decision on their plea for asylum reached 80,000, it became clear that a considerable number suffered from mental health problems. Due to the asymmetrical placement of asylum seekers in camps across the country, the magnitude of this problem was not noticed everywhere at the same time and the response of mental health institutions differed accordingly.
The largest centre for asylum seekers, Crailo, situated in the West of the country at one time accomodated 1,500 people. There it was that the Symfora Group, responsible for mental health care in that area, developed a programme . It became soon evident that the number of people needing treatment exceeded 10% of the camp population. It became clear that we had to deal with different groups of patients; people who had suffered from mental disease before they had started their trek to Europe, people who had been traumatized in their country of origine, people who had suffered extreme stressfull events during their flight, people who developed "normal" psychopathology, but also people who became traumatised because of the length of their asylum procedure.
We will describe the asylum procedure, its principles and its consequences. We will show how the diverse groups of patients came to our attention and how we organized our services accordingly. Finally we will show the adverse effects of the procedure on the mental well-being of the concerned.

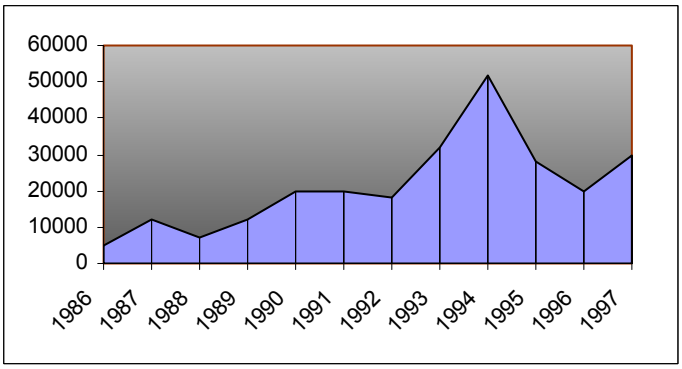
FACTS AND FIGURES

The moment an asylum seeker declares himself to the Dutch authorities he[1] is provisionally accepted into the asylum procedure. Within 6 working days a decision is taken whether his request is considered to have a realistic chance of success. If this is the case the asylum seeker is placed inside an AZC, Azielzoekerscentrum, Centre for Asylumseekers[2]. Most of these centres are situated within former army barracks or in any other empty building like abolished religious convents. Here they share rooms, kitchens and sanitary facilities with other asylum seekers. In

[1] for convennience's sake we use the word "he" for male and female asylum seekers
[2] In Europe only Denmark, Germany and the Netherlands have created camps to house asylum seekers

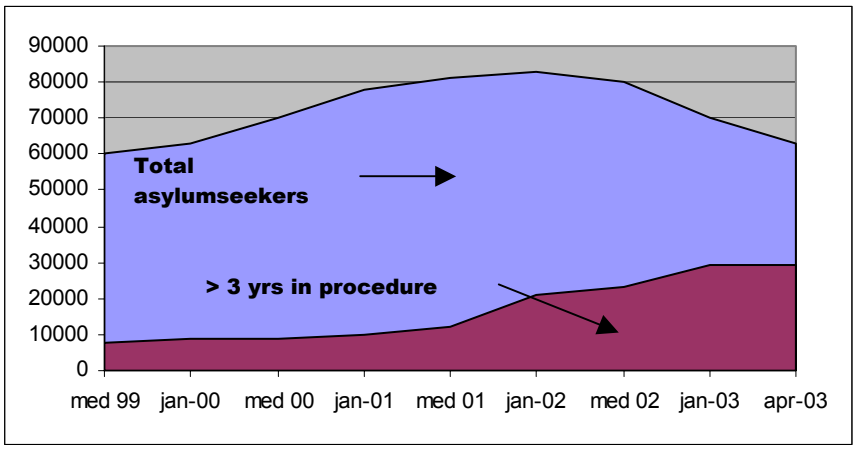
most cases facilities were not designed for a mixed population of men, women and children. For example the biggest Dutch AZC, Crailo, is located in part of an army camp, which is no longer in use. There is only very little privacy in toilets and showers. Often there are other factors which do not exactly make the life for asylum seekers easy. Next to Crailo a military shooting range is in daily use. There is also financial hardship. Adults receive €39 a week for and clothing, children under the age of 12 yrs add €6 to the family budget, those over 12 the impressive sum of €12. Asylum seekers are not allowed to earn an income for more than 12 weeks a year. It is possible to receive education, for example Dutch language, but as soon as the first application for asylum is turned down, this facilities is withdrawn.

FIGURE 1
Requests for political asylum
The Netherlands 1986 -1997[3]



A person is allowed to appeal against a negative decision, although the Dutch government has made this more difficult since the year 2000. These changes in legislation were meant to shorten the procedure. However when this new laws came into operation approximately 80.000 people were still waiting to hear whether they could stay or not. Many of them for a period which ranges from 5 to 9 years.

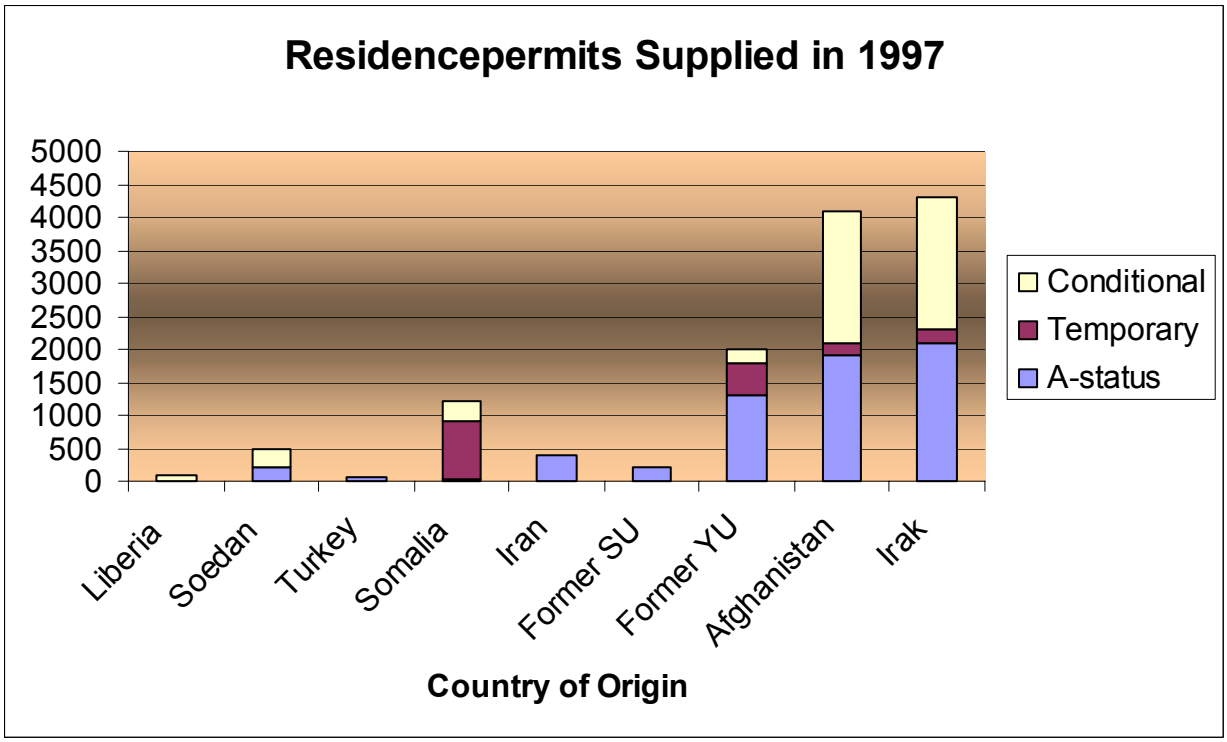
FIGURE 2
Average time spent waiting[4]



[3] Dutch Department of Justiced
[4] Vluchtelingenwerk Nederland

Most of this time spent in absolute idleness, no future, no past, no occupation, no education, no present.
Meanwhile the asylum seeker has ample time to think about the chance he has to be given a residence permit and what kind of permit this could be. In 1997 50.000 requests were handled by the Dutch authorities. For 17.000 people the outcome was positive .Of those 39% were officially recognised as political refugees. They, mainly Bosnians and Iraqi's, received the A-status[5]. Thirty percent was given a temporary status and another 30% a conditional permit.[6]

FIGURE 3



A FEELING TRANSLATED INTO RESEARCH

We might assume that the situation in which virtually all asylum seekers find themselves cannot be good for physical or mental health. It is true that at least temporarily they have escaped from whatever it was that made them take the decision to flee their country. But the fact is that in our daily work with asylum seekers we see the health of people deteriorate.
Some of our colleagues have tried to concretize this observation.
In our country Koppenaal, Bos and Broer investigated the causes of death of asylum seekers in the period 1998- 1999 by going through the registers kept by the Dutch authority responsible for the asylum seekers (COA). They found in a population of 38.000, respectively 54.000 people that 156 asylum seekers died, of whom 49 were given a non-natural cause of death. Interestingly enough the women from this population had a Standard Mortality Rate of 0,85 (SD 0,59 – 1,11), but the male asylum seekers had a significant greater chance to die in the Netherlands than their local counterparts. Their SMR was 1,23 (SD 1,01 – 1,42). Infectious disease (SMR 4,1) and non-natural

[5] A-status: a 5-yrs permission to stay; Temporary: permission can be withdrawn any moment; Conditional: on specified grounds, for example medical treatment
[6] Figures from the Dutch Deoartment of Justice

death (SMR 2,5) accounted for most of the extra mortality. Drowning, violent death and suicide (SMR 2,8). [a]This last figure brings us back to the field of mental health.
In one of many publications on this topic coming from Australia Silove and his colleagues discuss the effect of the asylum period on the mental health of asylum seekers They conclude in the year 2000 that *"concerns about uncontrolled migration have encouraged host countries to adopt policies of deterrence in which increasingly restrictive measures are being imposed on persons seeking asylum."*[b]. It is probably no coincidence that in the same year during the debate on new immigration laws in the Dutch parliament the proposed, and later accepted, legislation was promoted as a deterrent for prospective asylum seekers. Until then the Netherlands were obviously considered rather soft on immigrants.
We will not go into the effects of detention of asylum seekers who have not committed any crime other than seeking asylum. The effects on their mental health are succinctly described by a taskforce of the Physicians for Human Rights from the United States.[c] Not a document to brighten your day.
In the Netherlands Laban and colleagues found in a group of almost 300 Iraqi asylum seekers that of those who had arrived two or more years ago 62% had one or more psychiatric disorders (DSM-IV/ICHD) against only 42% in the group of recently arrived people. PTSD scored high in both groups, but their was no significant difference between the groups. Women had a three times higher risk than men to develop new psychiatric symptoms.[d] The conclusion must be that the longer the asylum procedure lasts, the more chance to develop psychiatric illness (other than PTSD).
Sinnerbrinck and Silove targeted a similar, although smaller, population and concluded likewise that already traumatised people are subjected to high levels of stress, which will compromise their already unstable mental health.[ef]
A short remark here. Laban did measure the caseness of the subjects in his population, whilst Sinnerbrinck and Silove measured symptomatology. We think that a combination of the result obtained by these research groups shows that it is the mental health of asylum seekers which is being compromised by the asylum procedure and that within this population we will find many pre-cases if we look carefully.
For those of us who are not involved in research but do grapple with the question how to help asylum seekers in our care and how to prevent a deterioration in their mental health we will now proceed to give some of our own thoughts on this problem.

WHAT WE GET AND WHAT WE SEE

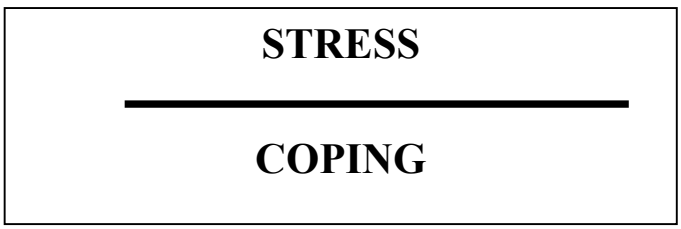
At the zenith of AZC Crailo it was inhabited by 1500 asylum seekers. At that time approximately 160 people (adults and children) were on file with our mental health service. A team to provide ambulatory mental health services had grown in a few years from one part-time community health nurse to two community mental health nurses, two psychiatric nurses, one general physician and one psychiatrist. All of them on a part-time assignment. When the number of people seeking asylum in the Netherlands started to decrease, the number of people living at Crailo went down to approximately 800. However the number of people in our care did not decrease, nor did the number of new cases.
We get our patients through the medical staff of the Centre (MOA). Referral is done whenever the health workers, mainly nurses, of MOA suspect the presence of severe psychiatric disorder (depression, psychosis) or have signals that the person is suffering from PTSD. Often multiple somatic complaints without satisfactory explanation is the main reason for referral.

At the first interview we almost always find that we get people who have been living in the AZC for quite some time, but also that there is a certain delay between the emergence of complaints and the seeking for help.
We have come up with several explanations for this phenomenon. The first is, that initially people are glad that they have arrived in a safe haven and that at least they have a roof above their heads. After a while however they find \that life in an AZC means mainly waiting. Kramer and others described how most asylum seekers start to think differently in the second phase, the waiting period.
"The long, seemingly endless continuing time without work, money en residence permit evokes different reactions in asylum seekers. Most indicate that they during de empty period of only waiting do think a lot about their past. They are waiting for a postponed future."[g] It could be that in this void the feelings of physical and mental unwell being become more and more important.
The second explanation stems from the fact that the MOA files show that the majority of asylum seekers upon arrival in the Netherlands (when a medical check-up is routine) did not mention any physical problems like headache, abdominal pains, backpain. Virtually every new patient we see has somatic complaints and thinks a lot about the past. It is possible that the stress which is present during the asylum procedure after a while cannot be compensated anymore by the initial relief of being saved and the expectations of a good future.
We are leaning towards the second explanation. Not only because it fits more in what we get and what we see, but also because it makes us a little bit more optimistic about the possibility to help people, as we will show in the last part of this paper. We stress however the words "a little bit more", because in this work there is no place for optimism.

THE POOR MANS BURDEN

The patients we see in Crailo can roughly be divided in three categories. First, and most obvious to other residents, is the group suffering from schizophrenia. This group consists of about 20 people, predominantly male, originating from all over the world. Usually we consider them to be old cases, meaning that already in their country of origin they were suffering from psychosis. Then there is the group of people with recent onset depression, anxiety or panic disorder without PTSD. They form the bulk of our caseload. Sometimes there is a history of mental disorder in the past, usually there isn't. From a psychodynamic point of view these patients have one thing in common: they have been strong enough to reach Crailo. This tells us something about their coping mechanisms. Finally we see a smaller group of people suffering from full-fledged PTSD. Signs and symptoms of disorder might or might not have been present before their quest for asylum.

Figure 4
The Vital Balance



Using the theory of the Vital Balance[7] as our tool, we can understand how over time our patients have struggled to maintain their mental health.
We can divide the road which has led the asylum seeker to our surgery in three stages:

- life in the home country
- flight
- asylum procedure.

Plotting this itinerary against the four aspects of the vital balance, we see the following.

Table 1
The vital balance under pressure

	STRESS		COPING	
	ACUTE	CHRONIC	COMPETENCE	RESOURCES
HOME	+++	++	individually determined	+++
FLIGHT	+++	+		---
CRAILO	+	+++		+/-

Acute stress had been encountered at home and during the flight. There might be moments of acute stress in Crailo, but these are few[8].
Chronic stress has undoubtedly been present in the home situation, during the flight acute life-events were clearly predominant, but the longer the stay in Crailo lasts the more the chronicity [h]becomes stressful.
Being the most individually determined aspect within the vital balance, the asylum seekers *competence* can be looked upon as quite stable during the phases home/flight/Crailo. But sometimes physical illness or disability contracted during the process will have diminished the individual competence. Finally the *resources.* It is clear that a considerable loss of resources will occur for a person fleeing his country and that it building a new network in an AZC is not always possible.
We all can, of course think of examples to illustrate the increased burden of stress and the decreased coping abilities of a person before he flees his country and during the flight.
The purpose of this paper, however, is to start a discussion on the factors which contribute to a further deterioration of the vital balance during the prolonged stay in an AZC and also to see whether there is anything we can do to stop this slide to mental disease. Remember that we are not only speaking about people already in our care, but also of those who are slowly losing their mental health during a prolonged period of waiting.
Boredom, cramped living situations, violence, illness of family members, witnessing others to be transported are only a few of the *chronic stressors* people encounter. *Resources* lost are family and friends, religious activities, language, money, education, recreation. It is clear that the burden of stress will increase and the resources continue to dwindle the longer the procedure lasts. Looking at it this way it is no surprise that there is a direct correlation between length of procedure and increase of mental disfunctioning.
Now in what we can mental health workers be pro-active in this matter. How can we help people who are in danger to develop serious mental problems during the time when they find themselves in a void? We can not give a person a status, nor work or a place to live. For most people there is

[7] Karl Menninger
[8] Recently moments of acute stress have been more frequent due to people being removed in "Nacht und Nebel"from the camp.

no future, they would rather not talk about the past, the present therefore does not exist either. We try to restore some of the self respect our patients used to have, to support him in his daily life so that he is better equipped for life at the AZC. We give hints and advices and sometimes antidepressants, antipsychotics, sleeping pills. We emphasise that we are not able to remove the traumatic experiences from their memory and that maybe time will heal some wounds.
We should, probably more than we do, try to reinforce the vital balance by making sure that someone is physically healthy and can get some tools to handle himself in AZC –life. In this way we increase the individual competence. We can supply resources by showing people ways to extend their network (sport, church, voluntary jobs). We can maybe decrease acute stress by taking a systems approach. By seeing the person as part of a family or clan and taking care of the other people also. What we cannot do on an individual basis is to remove the chronic stress brought about by the length of the procedure. But we can, and should, alert those responsible, professionals and politicians, of the dangers inherent in a procedure which not only takes away a big part of a persons life but can also be shown to be harmful. In this sense we have a duty which goes farther than talking to colleagues in national and international meetings. We should be active in our own community. Knowing what we know we cannot let things pass.

---

[a] Koppenaal, H; Bos, C.A and Broer,J, Hoge sterfte door infectieziekten en niet-natuurlijke doodsoorzaak oncer asielzoekers in 1998-1999, *Nederlands Tijdschrift voor Geneeskunde,* vol 147(9), 2003, 391-395

[b] Silove,D, Steel, Z and C.Waters, Policies of Deterrence and the Mental Health of Asylum Seekers, *JAMA,* vol. 284 (5), 2000, 604 -611;

[c] PHR, *From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers;* PHR Asylum Network, 2003, www.phrussa.org/campaigns/asylum-network/detention

[d] Laban, C,J. Psychiatrische stoornissen onder Irakese asielzoekers en het verband met de lengte van de asielprocedure., *Tijdschrift voor Gezondheidswetenschappen,* vol 81 (4), 2003, 13

[e] Sinnerbrinck, I and D.Silove, Compounding of Premigration Trauma and Postmigration Stress in Asylum Seekers, *The Journal of Psychology,* 131 (5), 1997, 463-470

[f] Silove, D, I.Sinnerbrinck, I.Field, V.Manicavassagar and Z.Steel, Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors, *British Journal of Psychiatry,* vol. 170 (1997), 351-357

[g] Kramer, S, Bala, J, van Dijk, R, Ory,F. *Making sense of experience,* 2003, page 48; University of Utrecht Press

TOWARDS AN AFROCENTRIC APPROACH TO PSYCHIATRY

Dan Lamla Mkize

Professor and Head: Department of Psychiatry
Nelson R Mandela School of Medicine
Faculty of Health Sciences
P/Bag x Congella, Durban, 4013
SOUTH AFRICA
Tel: +27-31-2604321
Fax: +27-31-2604322
Email: mkizedl@nu.ac.za

CULTURAL PSYCHIATRY

Cultural psychiatry was born in the realisation that a measure of ethnocentrism pervades scientific and especially international psychiatry and entails an active challenge to its universalism. Its goal was to demonstrate that as a function of culture there were differences attending the pursuit of typical clinical tasks of psychiatry. These were not just malfunction of specific chemical systems or lesions of anatomically discrete brain regions associated with psychiatric disorders. Instead, what was also needed to understand them properly was their social and cultural content. The latter required giving attention to how communities defined, understood, interpreted, valued, and realised their respective values and traditions in personal experience and symbolic behaviour. It was in relation to such locally shaped cultural psychologies and cultural constructions of the body and personhood that problems of mental health and illness acquired meaning and form.

The relation between culture and mental illness has changed significantly over the last 100 years. At the beginning of the last century cultural psychiatry was largely concerned with the description of exotic features of clinical syndromes found in Africa and other non-western locations. Today cultural psychiatry is concerned with interview across the cultural barrier, communication skills, cultural formulation, cultural identity, effects of acculturation, culturally specific therapies, ethnopsychopharmacology, pharmacogenetics and environmental factors [2].

AFRICAN PSYCHIATRY

Psychiatry has its roots not only in biological medicine but also in behavioural science. It cannot be divorced from the history of the society in which it is practised, and historically most African countries differ widely from North America and Western Europe. Yet psychiatric teaching and practice are based on the experience of Western societies, which may be inapplicable to Africa. To be effective, psychiatry must fit the African cultural pattern [3].

To have a clear understanding of the African view of mental illness, one must have a clear view of the African concept of the causes of mental illness. Although it is not possible to speak of a single African viewpoint, the different cultures south of the Sahara do share a consciousness of the world and an inventory and structure of tenets about it [4]. The African view of mental ill health currently encompasses a wide spectrum – from ancestors, folk belief and witchcraft, to modern

medical science. All the systems function simultaneously within the African culture and within the individual and easily fit and complement one another. This view also fits well into the biopsychosocial model. The problem for a long time has been the inability to bring the Western and traditional healing systems together. In traditional African cultures mental illness is integrated into social order and cosmic order. Each member of the culture has precise conceptual and operational models for the causes of the mental illness.

In African medicine the sick are treated or cared for in a particular way in terms of traditional African thinking, which is claimed as being different from Western thinking. A very important reason for this is that the African view of what a human being is differs from other views, especially from the so-called Western view. A view of human nature has wide implications for how people are treated in different life situations, e.g. as students, employees, subordinates, brothers and sisters, parents, children, and sick people. To treat people in a certain way in any specific situation implies a universal way of thinking with regard to human nature. This universal way of thinking may be termed a world view, a way of life, frame of reference, conceptual scheme, web of beliefs or view of life [4].

Care of the mentally ill in Africa has for centuries been in the hands of traditional and religious healers. Mental health has always been a part of general medical care; the concept of physical and psychological dualism is alien to Africa. With the introduction of hospital care, little has been done to integrate and refine indigenous resources. In many African countries the medical services are limited and poor. Some or most of them cannot afford to provide adequate mental health care, yet there has been little attempt to operate efficiently and with imagination using the restricted services that they can provide. The nature of psychopathological phenomena in these changing societies is not given enough weight in designing and operating national programmes of prevention and treatment of mental ill health. Western models are copied. Psychological theories are based on European civilisation are imposed on unrelated societies [3].

Most physical illnesses can be dealt with fairly satisfactorily, regardless of the culture of patient and doctor. This is not true of mental illness. Psychiatry is crucially informed by culture and other social, biological and psychological factors and processes. Cultures differ regarding their definition of health, ill health and healing. Western psychiatry now has much to offer to the African patient, but there are serious obstacles in the way. The chief obstacle is a fundamental difference in social and cultural background between doctor and patient [5].

AFRICAN PSYCHOTHERAPY

All traditional types of psychotherapy must obviously reflect local beliefs regarding human nature, and in many cultures this means that the close links between individuals, their ancestors, and the spirit world play a prominent role in treatment. Healing is based on the establishment and maintenance of satisfactory relationships between these different elements – the present, the past, and the spirit world. The patient, therefore, does not consider the illness as something to be cured or controlled but as something to be understood and acknowledged [5]. It is no longer a matter of explaining the mechanisms in order to control them, but of understanding a significance, a meaning. The question is not how but why things happen. To understand the meaning of the illness or of the symptoms introduces a further dimension into the relationship between the patient and those around him, and between the patient and those treating him. This concept goes much further than the Freudian psychoanalytical theory of symptoms as symbolic representations.

Psychoanalysis, like the rest of modern medicine, is centred on the concept of a failure of certain mechanisms within the individual. To the psychoanalyst these mechanisms are inherent in the patient's personality, which in its turn reflects his history and in particular his childhood. For the African therapist, on the other hand, the symptoms are manifestations of a conflict between the patient and other individuals, dead or alive, spirits and the non-material forces that pervade society. His first task is to grasp the social meaning of the symptoms. Knowing of the patient's culture he is able to say, for example, 'You have broken the taboos of your family and thus offended your ancestors; that is why you are ill'. The patient and his relatives must therefore try to understand the illness. It is the message of the illness that is feared not the patient himself. However disturbed he may be, the patient is not excluded or rejected. He is listened to and considered as a human being in the full sense. The illness is everybody's business; the family and the community are just as concerned as the victim who bears the message [6].

THERAPEUTIC COMMUNITY

The concept of a therapeutic community as a treatment strategy in psychiatry has a sizeable body of literature and was brought back into prominence in the 1950s. Despite similar objectives, concepts about the physical setup and the working of a therapeutic community differ and so do definitions in the literature. In the West, specifically in the mental health institutions, the definition of therapeutic community may include only patients from the same ward or selected others. In Africa, it tends to be more inclusive and larger, sometimes involving a chain of villages [7].

A therapeutic community is defined in terms of collaborative efforts between the therapist or medical practitioner and the patients. The term implies that the responsibility for treatment is not confined to the trained medical staff but is a concern also of the other community members and patients. Implied in this definition is that the hospital is a therapeutic community. From a wider perspective, the therapeutic community is a social structure with its own particular ways and laws, and is not to be confused with a setting in which one has freedom to do as one pleases without restriction. It has conscious design, and its main aim is to help the patient become a more mature and rational person, not merely as well as he once was [7].

Four therapeutic ideologies and principles guide the establishment of therapeutic communities: rehabilitation, permissiveness, democratisation, and communalism.

Briefly, *rehabilitation* implies normalising the patient to the total environment through the community assuming the dual functions of a treatment medium, and of representing the individual's microcosm in which he is faced with the reality, as much as possible, of life events. *Permissiveness* enjoins all the community members, patients, and staff to be tolerant of the distressful behaviour of the pathological members. Ideally, this should allow the pathological individual to demonstrate his difficulties and the community members to examine the basis for their own reactions.

According to the concept of *democratisation*, a 'blurring of role differences' is encouraged insofar as chaos is kept in check through every member of the community having to make responsible and constructive contributions. Communalism will be discussed later.

The best example of a therapeutic community is the Nigerian Aro village treatment centre, founded by Lambo [3]. The approach is rooted in the village system that permits treatment of the

mentally ill utilising inherent dynamic resources of the social environment as the principal therapeutic technique. It is a salutary blend of indigenous African psychotherapy, Western psychotherapy and medication. Patients who are admitted for treatment must be accompanied by a predetermined number of close relatives. In addition to medication, social activities geared towards normalisation of patients include watching movies, cultural activities, social dancing, church services and so on. In this way a smooth social, physical and psychological normalisation occurs, with have a low rate of illness recidivism and readmission. Similar programmes are reported to have begun in Ghana and a number of other African countries [7].

Emerging from this culture-community orientation in psychotherapy is an active intellectual movement among African psychiatrists and other practitioners in medicine and allied health professions calling for the integration of the traditional and Western modes of treatment. Several investigators found that psychiatric patients usually consulted traditional African doctors before coming to the Western treatment centres and mental hospitals. In fact, some managed to receive treatment from both mental hospitals and the traditional African healers even if this meant using a pseudonym to falsify records and various deceptions [7].

Some African countries have recognised indigenous healers and, in some cases have accorded them equal status with Western-trained medical practitioners. South Africa is in the process of acknowledging the important role of the African health care system and the role indigenous healers can play.

INTEGRATING WESTERN AND AFRICAN PSYCHIATRY

It is often believed that the view of modern psychiatry and psychotherapy is logical, while that of traditional therapies is palaeological. It is forgotten that both modes of thinking are prevalent in both settings. The rationale of Western psychotherapy resembles the rationale of primitive therapies in that it is not subject to disproof – it cannot be shaken by therapeutic failure [9]. It may not be possible to assert which view is more valid. To say that a certain neurotic behaviour is due to mental conflict or that a disturbed behaviour is due to an evil spirit is not saying anything very different. Neurotic has approximately the same meaning as disturbed and a conflict may be construed an evil spirit of some kind. If this is realised and no attempt is made at proselytising, therapy can progress smoothly. It must be realised that the two world views are not antithetical but complementary; one answers the how, and the other the why and the who behind the malady. The two views may well coexist and operate within selective contexts [10].

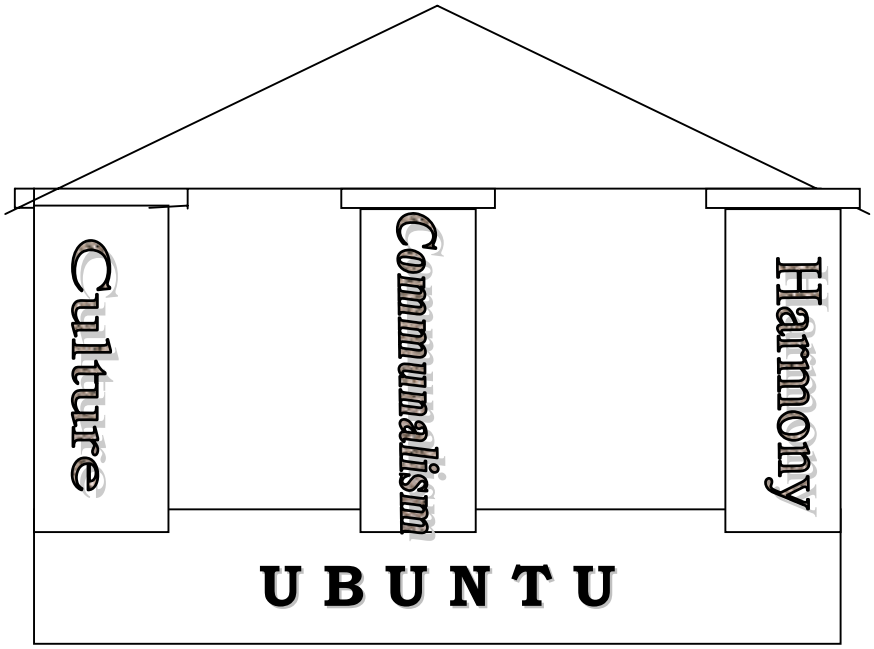
Gillian Straber [11], a psychologist working in Johannesburg, reports how an integration of African and Western healing methods helped to treat three young sisters suffering from post traumatic stress disorder. Through a detailed analysis of a dream shared by the three adolescent girls, she outlines many similarities between an African and a western understanding of their symptoms. She demonstrates how both systems acknowledge the symptoms to be a function of the breaching of stimulus boundaries, the existence of survivor guilt and the phenomenon of frozen mourning. She illustrates further how many factors considered part of Western psychotherapy are applicable to psychotherapy with African patients, for example catharsis following an emotional reliving of the trauma, re-ordering of perceptions following insight, and fostering hope for the future.

In South Africa psychiatric practice is mainly of the Western type. This is not unexpected as the majority of psychiatrists are white. There are about 20 African psychiatrists, all of them trained in

Western psychiatry. These few African psychiatrists should advocate for an Afrocentric approach to psychiatry based on a blending and integration of all facets of knowledge of the behavioural sciences, biology, ethnopharmacology, genetics, sociology and anthropology. The best psychiatry possible provides expert scientific diagnosis and therapy in the light of an appreciation of the role played by cultural factors in shaping human behaviour. African psychiatry should inform the government and society about human behaviour and societal response to a transition from oppression to freedom and to the HIV/AIDS pandemic. It must have explanations for the high prevalence of crime, murder and child rape. We need scientists qualified in the mental health field to conduct field research into those aspects of African culture that impinge on the prevention, diagnosis and treatment of mental illness.

THE WAY FORWARD

Having considered the history of psychiatry, the challenge is to develop a system that incorporates both approaches. This system should be based on the core African cultural value of Ubuntu.



Besides the four therapeutic ideologies that guide the establishment of therapeutic communities, African psychiatry should have a strong foundation of Ubuntu, with three pillars of Culture, Communalism and Harmony. Ubuntu involves sensitivity to the needs and wants of others, sharing and being sympathetic, caring, considerate, patient and kind. It means qualities such as warmth, empathy, understanding, communication, interaction, participation, reciprocation, harmony, a shared world view and co-operation [10].

CULTURE A KEY CONCEPT FOR PSYCHIATRY

Culture refers to meanings, values and behavioural norms that are learned and transmitted in the dominant society and within its social groups. Culture powerfully influences cognition, feelings, and self-concept as well as the diagnostic process and treatment decisions. Culture is therefore best conceptualised as a totality, composed of a complex system of symbols with subjective dimensions such as values, feelings, ideals, and objective dimensions including beliefs, traditions, and behavioural prescriptions, articulated into laws and rituals. This unique capacity of culture to bind the objective world of perceived reality to the subjective world of the personal and intimate lends it its powerful role as expressor, mediator, and moderator of psychological processes and, ultimately, emotional disorders [2].

The concept of communalism has been discussed above. *Communalism* involves a broadly based social interaction and commonality of purpose for the mutual benefit of all members of the therapeutic community. Such a communal atmosphere is expected to engender sharing, informality, social connectedness, and freeing of communication to give patients the feeling of being included and belonging to the system. In some African communities where the equilibrium of the traditional life pattern is still relatively undisturbed these four basic elements of a therapeutic community are a natural part of the community network and only await a systematic rechanneling toward therapeutic ends [8].

Harmony - a state of being free from disagreement or ill-feeling; being a consistent whole.
An individual needs to be in harmony with self, family, community, environment and the universe. Mental illness is an indication of the disharmony in one or more of the above areas. This concept is similar to the biopsychosocial approach.

REFERENCES

[1] H. Fabrega. Epilogue. *The Psychiatric Clinics of North America* 2001; **3** : 595-607.

[2] M. Trujillo. Cultural Psychiatry In : Comprehensive *Textbook of Psychiatry* Vol 11 6th ed. Kaplan H I, Sadock BJ eds. Baltimore/London : Williams and Wilkins 1995 : 492-499.

[3] T.A. Lambo. Psychiatry in the tropics. *Lancet* 1965; **2** : 1119- 21.

[4] J. S. Neki, B. Joinet , M. Hogan, J.G. Hauli, G. Kilonzo. The cultural perspective of therapeutic relationship – a viewpoint from Africa. *Acta psychiatrica Scandinavica* 1985 ; **71** : 543-550.

[5] Editorial. Psychiatry for Africa. *South African Medical Journal* 1979; **55** : 149 –150.

[6] T.W. Harding. Traditional healing methods for mental disorders. *WHO Chronicle* 1975; **31** : 437-440.

*[7] M. Jones. The Concept of a Therapeutic Community. American Journal of Psychiatry 1956 ; **1** : 647-650.*

[8] D. Awanbor. The Healing Process in African Psychotherapy. *American Journal of Psychotherapy* 1982 ; **36** : 206-213.

[9] S. Romm . A sketch of man's efforts to mend his troubled mind. *The Psychiatric Clinics of North America* 1994; **17** : 453-469.

[10] G. Straber. Integrating African and Western Healing Practices in South Africa. American Journal of Psychotherapy 1994, **48** : 455-467.

[11] E.D. Prinsloo. A comparison between medicine from an African (Ubuntu) and Western philosophy. *Curationis* 2001; **24** : 58-65.

Dissociative Symptoms and Reported Trauma among Patients with Spirit Possession and Matched Healthy Controls in Uganda.

Marjolein van Duijl, M.D., Ellert Nijenhuis, Ph.D., Ivan Komproe, Ph.D., Joop de Jong M.D., Ph.D.

Correspondence: E.M. van Duijl, Regional center for Mental Health, GGZ Winschoten, PO Box 286, 9670 Winschoten, the Netherlands

Abstract

Background

Spirit possession is a common, although controversial, worldwide phenomenon with dissociative features. Studies in Europe and the US have revealed associations among psychoform and somatoform dissociation, and (reported) trauma.

Aims

To explore the relationships between spirit possession, dissociative symptoms, and reported potentially traumatizing events in Uganda.

Method

119 persons with spirit possession, diagnosed by traditional healers, were compared to a matched control group of 71 "non-possessed" persons. Assessments included demographic items, and measures of dissociation and potentially traumatic events.

Results

Compared to the non-possessed group, the possessed group had more severe psychoform dissociation and somatoform dissociation, and reported more potentially traumatizing events. The associations between these events and both types of dissociation were very strong. Yet, consistent with the cultural perception of dissociative symptoms, the participants subjectively did not associate dissociative symptoms with potentially traumatic events.

Conclusions

Findings confirm a relationship between potentially traumatizing events and psychoform and somatoform dissociation, and are at odds with the interpretation that the link between dissociative symptoms and trauma result from suggestion.

Background

Dissociative phenomena occur worldwide, and as you have seen in the former presentation, also in Uganda. Unfortunately it is not a well covered issue in the education of mental health professionals in most countries, probably the problems concerning dagnosis, classification and the controversial ideas about etioligy play a role.

In western countries retrospective and perspective longitudinal studies have shown that actual and repeted traumatic experiences are correlated with dissociation.(Ogawa)

In western countries many studies have shown that dissociative symptoms have related to potential traumatic experiences such as physical and sexual abuse, rape, early loss experiences and consequences of disasters and war (Nijenhuis, Putnam, Irwin)

Others are sceptical towards this relationship: (Loftus, Mair and Brown in the British literature and Merkelbach in the Netherlands) doubt the accuracy of reported traumatic memories.
They warn that they are the result of a suggestive environment induced by the therapeutic or juridical context.

In non – western cultures spirit possession is a common phenomenon, not only in Africa and Asia but also in America and Europe.
The DSM IV provides the possibility to classify pathological forms of spirit possession as Dissociative trance disorder (DTD) and possessive trance disorder (PTD) in the category D.D. not otherwise specified. This is the result of a discussion where the former versions of DSM classification were not considered appropriate for the majority of the world population.
The problem of including Cultural Bound Syndroms as DTD and PTD is that they loose some of their original context of meaning. This problem is called category fallacy. Antropological studies often see spirit possession as a collective reaction to contextual problems (suppression, poverty).

This study was carried out in Uganda, where in the process of my work as a psychiatrist, I increasingly came across dissociative features, with spirit possession as a clarification on the ward, and in the (outreach) clinics.

As you are all aware there is a lot of psychological traumatisation in Uganda due to war and rebels (questions about a possible return of Amin before his death have touched some of this traumatic past), poverty, aids and infections diseases causing loss and bereavement, social disruption and changes.

At the same time medical, psychiatric and psychological services are limited and the population depends mainly on churches and traditional healers to find relief.

Qualitative research showed that according to the participants of the FG's and the Key informants spirit possession occurs a lot – whilst traditional healers do not attribute it to "emotional" trauma.(van Duijl, submitted)

Aim:
To explore correlations between spirit possession, (local idioms of distress), dissociative symptoms and traumatic experiences in Uganda by means of a case control study.
The following hypotheses were tested:
1. There is a relationship between spirit possession and dissociation
2. There is a relationship between spirit possession and traumatic experiences
3. Also in Uganda dissociation and potential traumatic experiences are correlated.

Methodology of the Research:
This is a control study where the case group consisted of 119 patients suffering from 'spirit possession' identified by the traditional healers in Mbarara Bushennyi and Ntungamo District.
The control group consisted of 71 healthy persons from the same villages.
The case and control group matched in gender, age and education level.

A set of questionnaires were administerd. They were translated into Runyankoore as required: translation, backtranslation, final version agreed in a focus group of professionals.

A cultural questionnaire based on the results of the FGD's with local dissociative symptoms was used to confirm the difference between the case and control group.

The TEQ and HTQ measures reported traumatic experiences and the DES and SDQ measure the psycoform and somatoform dissociative symptoms.

Results:
The possessed group has more locally defined symptoms for dissociation / possession (2,8) measured with the CDS Ug.The non possessed group has a score of zero.
These are: amnesia, narrowed consciousness, hearing of voices, talking with voices of others, repetitive movements outside one's control.

Hypothesis 1

Possessed people have more dissociative symptoms measured with the DES for psychoform symptoms and SDQ 20 for somatoform symptoms.

Hypothesis 2

- The possessed group has gone through more cumulative trauma than the nonpossessed group measured with the TEC.

- In this slide items of the TEC have geen grouped into trauma clusters: loss experiences are high in both groups. Bodily threat which includes items as serious injury, pain, wartime experience and emotional neglect and abuse statistically occur more amongst possessed patients.

- This slide shows the reported traumatic experiences with the HTQ.
  Items vary from lack of food, imprisonment, murder of a family-member and torture.

All events occur more often with the possessed group except for imprisonment.

Hypothesis 3
Relationship between dissociative symptoms and traumareporting.
All correlations are high.
Regression Analysis shows that of the types of trauma somatoform disorder is best predicted by bodily threat, that included serious injury, life threatening pain, wartime experience.
Manova (multivariate analysis) confirms that there is no main effect for group that influence the association between dissociative symptoms and traumareporting.

Discussion
Findings are similar to findings in western countries concerning relationship dissociation – traumatic experiences.
- strong relationship somatoform and psychoform dissociation
- dissociation and reported trauma.

It is very unlikely that the latter is due to suggestion (as some critics have posed).Both healers and patients do not see traumatic experiences as a cause of spirit possession (which implies the dissociative symptoms).

Limitations

- Research is not double blind
- Taboo concerning reporting of trauma (sexual abuse) can influence reliability, possibly traumatic experiences are even higher.
- Healthy controls possibly do not have an interest in reporting traumas
- A local category (spirit possession) is being compared to "western" symptoms and explanations (trauma): problems of category fallacy. Ancesteral conflicts can also be Traumatic?

Clinical implications

- Spirit possession presenting DTD and PTD deserve more attention in research, education of (mental) health professionals and treatment of trauma related problems
- The role of traditional healing in the treatment of dissociation and possible underlying traumatic experiences deserves further research

Dissociative Symptoms and Reported Trauma among Patients with Spirit Possession and Matched Healthy Controls in Uganda.

references

1. American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM-IV). American PsychiatricAssociation: Washington DC.

2. Antze, P. (1992) Possession Trance and Multiple Personality: Psychiatric Disorders or Idioms of Distress ? *Transcultural Psychiatric Research Review.* 29, 319-323.

3. Bartholomew, R.E. & Wessely S. (2002) Protean nature of mass sociogenic illness, from possessed nuns to chemical and biological terrorism fears. *British journal of psychiatry,* 180, 300-306

4. Barton, Tom & Mutiti, Alfred. (1998) NUPSNA, *Northern Uganda Psychosocial Needs Assessment.* Unicef. Marianum Press, Kisubi, Uganda.

5. Behrend H.& Luig U., (1999) Introduction in *Spirit Possession, Modernity and Power in Africa.* (eds H. Behrend & U. Luig) James Currey Ltd, Oxford.

6. Bernstein E., & Putnam F.W. (1986). Development, reliability, and validity of a Dissociation scale. *Journal of Nervous and Mental Disease*, 102, 280-286.

7. Boddy, A. (1992) Comment on the Proposed DSM-IV Criteria of Trance and Possession Disorder. T*ranscultural Psychiatric Research Review,* 29:323-330

8. Boon. S, & Draijer, N. (1995). *Screening en diagnostiek van dissociatieve stoornisse*. Lisse: Swets & Zeitlinger.

9. Bourguignon, E. (1992) The DSM-IV and Cultural Diversity. *Transcultural Psychiatric Research Review,* 29:330-332.

10. Brown, P. (1995). Multiple personality disorder in the Netherlands: A study on the reliability and validity of the diagnosis by S. Boon & N. Draijer [Book review]. *Australian and New Zealand Journal of Psychiatry*, 29, 178-179

11. Cardena, E. (1992) Trance and Possession as Dissociative Disorders. *Transcultural Psychiatric Research Review*, 29:287-300.

12. Cardena, E. (1996) Dissociative Disorders: Phantoms of the Self. In S.M.Turner and M. Hersen (eds.) *Adult Psychopathology and Diagnosis,* pp. 384-403. New York: J. Wiley

13. Castillo, R.J. (1994a) Spirit Possession in South Asia, Dissociation or Hysteria? *Culture, Medicine and Psychiatry,* 18: 1-21.

14. Castillo, R.J. (1994b) Spirit Possession in South Asia, Dissociation or Hysteria? Part 2: Case Histories. *Culture Medicine and Psychiatry,* 18: 141-162.

15. Castillo, R.J., (1992) Cultural Considerations For Trance and Possession Disorder in DSM-IV. *Transcultural Psychiatric Review,* 29:333-337.

16. Castillo, R.J. (1998) Culture and Dissociation. *Meanings of Madness, ,* pp.223-244. USA Brooks: Cole Publishing Company

17. Goff, D.C.; Brotman, A.W.; Kindlon, D.; Waites, M.; Amico, E.: (1991) The delusion of possession in chronically psychotic patients. *The Journal of Nervous and Mental Disease*179 (9): 567-571

18. Irwin, H.J. (1994). Proneness to dissociation and traumatic childhood events. *Journal of Mental Diseases* 182,.456-60.

19. Jong, J. T.V.M. de, A *Descent into African Psychiatry.* Royal Tropical Institute, Amsterdam, 1987.

20. Mair, K. (1999) Development of a Dogma Multiple Personality. *The Psychologist.* Vol 12 No 2.

21. Musisi, S. (1998): The psychological consequences of war traumatization on the women of Luweero District. In: The short term intervention of the psychological and gynacological consequences of armed conflict in Luwero District (Uganda) Isis-WICCE report (1998) Kampala, Uganda.

22. Kenny, M (1993) Multiple Consciousness/False Consciousness? *Transcultural Psychiatry,* 35(1):125-135.

23. Kirmayer, L.J. (1996) Confusion of the Senses Implications of Ethnocultural Variations in Somatoform and Dissociative Disorders for PTSD. In: A.J.Marsella, M. J. Friedman, E.T. Gerrity, R.M. Scurfield (Eds.) *Ethnocultural Aspects of Posttraumatic Stress Disorder,* 131-163. Washington DC, American Psychological Association.

24. Kirmayer, L.J. (1998) The Fate of Culture in DSM-IV. *Transcultural Psychiatry,* 35(3): 339-342.

25. Koss-Chioino (1992) Possession/Trance and Psychopathology Mismatched Conceptual Constructs. T*ranscultural Psychiatric Research Review,* 343-345.

26. Leavitt, J. (1993) Are Trance and Possession Disorders ? *Transcultural Psychiatric Research Revieuw,* 30:51-57.

27. Lewis-Fernandez, R (1998) A Cultural Critique of the DSM-IV Dissociative Disorders Section. *Transcultural Psychiatry,* 35(3): 387-400.

28. Lewis-Fernandez, R. (1992) The Proposed DSM-IV Trance and Possession Disorder Category: Potential Benefits and Risks. *Transcultural Psychiatric Research Review,* 29: 301-317.

29. Lewis-Fernandez, R (submitted) Comparative phenomenology of attacks de Nervios, Panic Attacks and Panic Disorder. Culture, Medicine and Psychiatry

30. Loftus, E.F. (1993). The reality of repressed memories. *American Psychologist*, 48, 518-537.

31. Lynn, S.J., Rhue, J.W., & Green, J.P. (1988). Multiple personality and fantasy proneness: Is there an association or dissociation? *British Journal of Experimental and Clinical Hypnosis, 5, 138-142.*

32. Nijenhuis, Drs. Ellert R.S., Philip Spinhoven, Richard van Dyck, Onno van der Hart, Johan Vanderlinden*, Degree of Somatoform and Psychological Dissociation in Dissociative Disorder is Correlated with Reported Ttrauma*. Amsterdam, 1996.

33. Nijenhuis, E.R.S., Spinhoven, Ph., Van Dyck, R., Van der Hart, O., & Vanderlinden, J. (1997). The development of the Somatoform Dissociation Questionnaire (SDQ-5) as a screening instrument for dissociative disorders. *Acta Psychiatrica Scandinavica,* 96, 311-318.

34. Nijenhuis, E.R.S., Spinhoven, Ph., Van Dyck, R., Van der Hart, O., & Vanderlinden, J. (1998a). The psychometric characteristics of the Somatoform Dissociation Questionnaire: A replication study. *Psychotherapy & Psychosomatics*, 67, 17-23.

35. Nijenhuis, E.R.S., Spinhoven, Ph., Vanderlinden, J., Van Dyck, R., & Van der Hart, O. (1998b). Somatoform dissociative symptoms as related to animal defensive reactions to predatory threat and injury. *Journal of Abnormal Psychology*, 107, 63-73.

36. Nijenhuis, E.R.S., Vanderlinden, J., & Spinhoven, Ph. (1998c). Animal defensive reactions as a model for trauma- induced dissociative reactions*. Journal of Traumatic Stress*, 11, 243-260.

37. Putnam, F.W. (1992). Multiple personality disorder. *British Journal of Psychiatry*, 161, 415-416.

38. O'Connel, M.C. (1982) Spirit Possession and Role Stress Among the Xesibe of Eastern Transkei. *Ethnology,* 21: 21-37.

39. Ogawa JR, Sroufe LA, Weinfield NS, Carlson EA, Egeland B. (1997) Development and the fragmented self: longitudinal study of dissociative symptomatology in a nonclinical sample. *Dev Psychopathol* 9(4):855-79.

40. Royal College of Psychiatrists, The (1997) Reported recovered memories of child sexual abuse: Recommendations for good practice and implications for training., continued professional development and research. *Psychiatric Bulletin* 21, 663-665

41. Van der Hart, O., Boon, S. & Op den Velde, W. (1991). *Trauma en dissociatie*. [Trauma and dissociation] In O. Van der Hart (Ed.), Trauma, dissociatie en hypnose [Trauma, dissociation, and hypnosis] (pp. 55-71). Amsterdam/Lisse: Swets & Zeitlinger.

42. Van Ijzendoorn, M.H., &Schuengel, C. (1996). The measurement of dissociation in normal and clinical populations. Meta- Analytic validation of the Dissociative Experience Scale (DES*). Clinical Psychology Review*, 16, 365-382.

43. Van Ommeren, M., Sharma, B., Komproe, I., Sharma, G.K., Cardena, E., Thapa, S., Poudyal, B.,Makaju, R. &de Jong, J.T.V.M. (2000*). Trauma and loss are determinants of epidemic illness in a Bhutanese refugee community.* Submitted.

44. Ward, C. (1980) Spirit Possession and Mental Health: A Psycho-Anthropological Perspective. *Human Relations,* 33(3): 149-163.

THE VALIDITY OF DSM-IV DISSOCIATIVE DISORDERS CATEGORIES IN SOUTHWEST UGANDA

Marjolein van Duijl, M.D.*
Etzel Cardeña, Ph.D.**
Joop de Jong, M.D., Ph.D.***

* Center for Mental Health, GGZ Winschoten, The Netherlands;
** Department of Psychology and Anthropology, University of Texas-PanAmerican;
***Free University of Amsterdam and Transcultural Psychosocial Organisation, the Netherlands

GGZ Winschoten,
PO Box 261, 9670 AG Winschoten,
The Netherlands
Email address: marjolein.vanduijl@planet.nl

ABSTRACT

There is little systematic research on the cross-cultural validity of the dissociative disorders, especially in non-western countries. This study evaluates the fit of DSM-IV classification and concepts of the dissociative disorders to local concepts, experiences and local presentations in Southwest Uganda. We conducted focus group discussions with medical students, traditional healers, religious leaders, counselors, community members, and other health workers (n=48). They were supplemented by key informant interviews with religious people, traditional healers, and traditional leaders (n=11). The responses were subjected to thematic analysis. Dissociative amnesia and depersonalization were generally recognized and seen as the result of traumatic experiences and were useful categories in Uganda. However, dissociative fugue did not match local concepts and was confused with spirit possession and other conditions such as alcoholic fugues and dementia. The description of dissociative identity disorder was always interpreted as a possession trance disorder by the local healers. There is only partial support for the validity in Uganda of the DSM-IV classification of dissociative disorders.

Results: DSM-IV and Related Dissociative Categories

	Relationship w/trauma Need for counseling	Caused by spirits	DSM IV category relevant in Uganda
DSM categories:			
Dissociative Amnesia	+++		+
Depersonalization	++	+	+
Dissociative fugue	+	++	?
Dissociative identity disorder		+++	-
Possession Trance disorder		+++	+
Dissociative Trance disorder		+++	+
Non-DSM categories:			
Hysteria	+ Unanswered sexual need		
Possessed by animals		+ Guilty of stealing	

+ : present in Uganda; - : absent in SW Uganda; ? : questionable presence

REFERENCES:

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders, fourth edition* (DSM-IV). American Psychiatric Association: Washington DC.

Behrend H., & Luig U. (1999) (Eds.). *Spirit possession, modernity and power in Africa.* Oxford, UK*:* James Currey.

Barton, T., & Mutiti, A. (1998). *NUPSNA, Northern Uganda Psychosocial Needs Assessment.* Kisubi, Uganda: Unicef Marianum Press.

Boddy, A. (1992). Comment on the proposed DSM-IV criteria of trance and possession disorder. *Transcultural Psychiatric Research Review,* 29, 323-330.

Bourguignon, E. (1992). The DSM-IV and cultural diversity. *Transcultural Psychiatric Research Review, 29*, 330-332.

Cardeña, E. (1992). Trance and possession as dissociative disorders. *Transcultural Psychiatric Research Review, 29*, 87-300.

Cardeña, E. (1994). The domain of dissociation. In S. J. Lynn and J. W. Rhue (Eds.) *Dissociation: Clinical, theoretical, and research perspectives* (pp. 15-31). New York: Guilford.

Cardeña, E., & Gleaves, D. (2003) Dissociative disorders. In S. M. Turner & M. Hersen (Eds.), *Adult psychopathology & diagnosis. Fourth edition* (pp. 476-505). New York: Wiley.

Castillo, R .J. (1998). Culture and dissociation. In R. J. Castillo (Ed.) *Meanings of Madness* (pp.223-244). Pacific Grove, CA: Brooks/Cole.

Chase, T. (1987). *When rabbit howls: The troops for Truddi Chase.* New York: Dutton.

Coons, P.M., Bowman, E.S., Kluft, R.P., & Milstein, V. (1991). The cross cultural occurrence of MPD: ADDitional cases from a recent survey. *Dissociation, 4,* 124-128.

De Girolamo, G., & McFarlane, A C. (1996). The epidemiology of PTSD: a comprehensive review of the international literature. In A. J. Marsella, M.U. Friedman, E. T. Gerrity, & R. M. Scurfield (Eds.) *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications* (pp. 33-85). Washington, DC: American Psychiatric Press.

De Jong, J. T.V.M. (1987). A *descent into African psychiatry.* Amsterdam: Royal Tropical Institute.

Flick, U (1998). *An introduction to qualitative research*. London: Sage.

Giles, L.L. (1999). Spirit possession & the symbolic construction of Swahili society. In H. Behrend & U. Luig (Eds.), *Spirit possession, modernity and power in Africa (pp.).* Oxford, UK*:* James Currey.

Glass, J. M. (1993). *Shattered selves: Multiple personality in a postmodern world.* Ithaca, NY: Cornwall University Press.

Grisaru, N., Budowski, D., & Witztum, E. (1997). Possession by the "Zar" among Ethiopian immigrants to Israel: Psychopathology or culture-bound syndrome? *Psychopathology, 30,* 223-233.

Hardon, A., Boonmongkon, P., Streefland, H., Lim Tan, M., Hongvivatana,T., van der Geest, S., van Staa, A., & Varkevisser, C.(1995). *Applied health research manual, anthropology of health and health care.* The Netherlands, Royal Tropical Instituut and University of Amsterdam.

Hyams, K. C., Wignall, S., & Roswell, R. (1996). War syndromes and their evaluation: From the U.S. Civil War to the Persian Gulf War. *Annals of Internal Medicine, 125,* 398-405.

Kleinman, A. (1988). *Rethinking psychiatry, from cultural category to personal experience.* New York: The Free Press.

Koss-Chioino, J.D. (1992) Possession/trance and psychopathology: Mismatched conceptual constructs. T*ranscultural Psychiatric Research Review, 29,* 343-345.

Lewis-Fernandez, R. (1992). The Proposed DSM-IV Trance and Possession Disorder Category: Potential benefits and risks. *Transcultural Psychiatric Research Review, 29,* 301-317.

Lewis-Fernandez, R (1998). A cultural critique of the DSM-IV dissociative disorders section. *Transcultural Psychiatry, 35,* 387-400.

Lynn, S. J., & Judith W. R. (1994). *Dissociation: Clinical and theoretical perspectives*. New York: Guilford.

Micale, M. S. (1995). *Approaching hysteria, disease and its interpretations*. New Jersey: Princeton University Press.

Musisi, S., Kinyanda, E., Liebling, H., Kiziri-Mayengo, R., & Matovu, P. (1999). The short term intervention of the psychological and gynecological consequences of armed conflict in Luwero District (Uganda). Kampala, Uganda: Isis-WICCE report.

Nijenhuis, E.R.S., Spinhoven, Ph., Van Dyck, R. Van der Hart, O., & Vanderlinden, J. (1998). Degree of somatoform and psychological dissociation in dissociative disorder is correlated with reported trauma. *Journal of Traumatic Stress, 11*, 711-730.

Ogawa, J. R, Sroufe, L. A., Weinfield, N. S., Carlson, E. A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Developmental Psychopathology, 9*, 855-79.

Ross, C. A., Duffy, C. M., & Ellason, J. W. (2002). Prevalence, reliability and validity of dissociative disorders in an inpatient setting. *Journal of Trauma and Dissociation, 3,* 7–17.

Saxena, S., & Prasad, K., V. (1989). DSM-III subclassification of dissociative disorders applied to psychiatric outpatients in India. *American Journal of Psychiatry, 146,* 261–262.

Spiegel, D., & Cardeña, E. (1991). Disintegrated experience: The dissociative disorders revisited. *Journal of Abnormal Psychology*, *100* , 366-378.

Spiegel, D., & Cardeña, E. (1996). Nosological comments on cultural diversity of dissociative and somatoform disorders. In J. Mezzich, A. Kleinman, H. Fabrega, & D. Parron (Eds.), *Culture & psychiatric diagnosis: A DSM-IV perspective* (pp. 163-167). Washington, DC: American Psychiatric Press.

Spiegel, D., Koopman, C., Cardeña, E., & Classen, C. (1996). Dissociative symptoms in the diagnosis of acute stress disorder. In L. Michelson & W. J. Ray (Eds.), *Handbook of dissociation* (pp. 367-380). New York: Plenum.

Tseng, Wen-Shing (1999). Culture and psychotherapy : Review and practical guidelines. *Transcultural Psychiatry, 36,* 131-179.

Van Ommeren, M., de Jong, J. T. V. M., Sharma, B., Komproe, I., Thapa, S., & Cardeña, E. (2001). Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Archives of General Psychiatry, 5,* 475-482.

Van Ommeren, M., Sharma, B., Sharma, G. K., Komproe, I., Cardeña, E., & de Jong, J. T. V. M. (2002). The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: Examination of comorbidity with anxiety and depression. *Journal of Traumatic Stress, 15,* 415-422.

ARE EXPLANATORY MODELS OF MENTAL ILLNESS DISEASE-OR CULTURE-SPECIFIC?

T. Stompe[1,2],
K. Ritter[1],
G. Ortwein-Swoboda[2],
W. Zitterl[1,2], H. Schanda[1,2],
H.R. Chaudhry[3], F.-S. Kohl[4]

[1] University Clinic for Psychiatry Vienna,
[2] High Security Hospital Göllersdorf,
[3] Fountain House Lahore,
[4] Clinique Universitaire de Psychiatrie Nice

ABSTRACT

This study examines the beliefs about the causes of mental distress of Austrian and Pakistani patients with schizophrenia or obsessive compulsive disorder. In order to estimate which proportion of these illness beliefs is caused by culture and which is specific for certain mental illnesses, data of both patient groups were sampled in Vienna and in Lahore, respectively. Participants were 373 adults (125 patients with schizophrenia and 58 with obsessive-compulsive disorder from Austria; 120 patients with schizophrenia and 70 with obsessive compulsive disorder from Pakistan). All patients were diagnosed according to DSM-IV by means of SCID 1. Participants who met the criteria of schizophrenia or obsessive-compulsive disorder completed a questionnaire on etiological representations of mental disorders developed by F.-S. Kohl. This questionnaire is based on items derived from categories published by Murdock et al. (1978) and Foster (1976). Seven factors were identified by means of factor analysis. These include: magic, somatic illness, life-event, guilt, stress, broken taboos and burden. The comparison of these dimensions indicates that explanatory models of mental illness are more culture- than disease-specific. Pakistani patients in general believe more often that mental illness is caused by mystical reasons, while Austrians prefer stress, somatic illness or burden as explanatory models. But we found also patterns of representation distinguishing between the two diseases within one culture: Schizophrenic subjects of both cultures more often thought that life-events are responsible for their health problems.

INTRODUCTION

"Explanatory models of mental disorders denote notions about an episode of sickness and its treatment by all those engaged in the clinical process" (Kleinman 1980). This includes beliefs concerning aetiology, course and meaning of the illness. A view on the literature shows the growing interest on emic concepts during the last thirty years (Edergton 1966; Westermeyer and Wintrob 1979; Ilechukwu 1988; Bughra 1989; Eskin 1989; Eisenbruch 1990; Weiss et al 1995; Patel 1995; Edman and Koon 2000; Kulhara et al 2000). But there are still existing many open questions concerning the varying concepts of causation of illness.
The aim of our study was to investigate whether the patients' illness concepts are primarily product of culture bound cognitions or show illness-specific characteristics independent from culture.

We decided to use a 41-item questionnaire designed by Kohl (unpublished manuscript) to explore how people from different cultures explain mental disorders. The objective of this study was to examine the quality of the translation of this questionnaire which is a modified variant of the Mental Distress Explanatory Model Questionnaire (MDEMQ) developed by Eisenbruch (1990). Eisenbruch as well as Kohl used results of the analyses of the chapter on cultural illness and health of the World Ethnographic Atlas by Murdock et al. (1978) to supplement the items included into the questionnaires; both of the authors selected slightly different items for the final version.

.

METHOD

Questionnaire

The original French version of the questionnaire was translated into English and German in co-operation by experienced psychiatrists and interpretors (Appendix). We called the English version of the questionnaire "**C**ausal **E**xplanations of **M**ental **D**isorders" (CEMD). The patients were asked how likely it is that each of the listed causes could contribute to their illness; they were told that there is no wrong or right answer and were asked to respond on a 4-point Likert scale ranging from "Yes, very likely"to "no, not likely at all".

Subjects

The study was conducted in the psychiatric university hospitals of Vienna and Lahore. Two patient groups with schizophrenia and obsessive-compulsive disorder of both countries were classified according to DSM-IV (Frances et al 1995) by means of SCID 1. Finally a total of 373 subjects volunteered to complete the questionnaire. Their basic clinical and socio-demographic data are presented in table 1. The sample included 183 Austrian patients (125 with schizophrenia, 58 with obsessive-compulsive disorder) and 190 Pakistani patients (120 with schizophrenia, 70 with obsessive-compulsive disorder).

Statistics

We used factor analysis for investigating the causal attributions of mental illness. Principal component analysis and varimax rotations were performed to derive meaningful scales out of the 41 items. The resulting scales were tested for reliability by means of Cronbach's α. Finally inter-group comparisons of the mean-values of the scales (One-Way ANOVA, Duncan test) were done in order to estimate in which extent illness concepts are culture- or disease-specific.

RESULTS

Statistical procedure to determine items that form dimensions of causal explanations of mental illness. The result of the factor analysis showed a seven factor structure accounting for 72% of the variance. Table 2 presents the items with the highest loadings in each of the 7 factors: Factor 1 "magic" (4 items: "bad or ominous dreams", "deliberate evil eye", "dangerous unprovoked spirit", "unwittingly casting an evil eye"), factor 2 "life-event" (3 items: "financial problems", "unemployment", "accident"), factor 3 "guilt" (3 items: "results of deeds and activities", "sin against God", "only a miracle can cure the illness"), factor 4 "stress" (2 items: "overwork", "consequence of modern life"), factor 5 "somatic illness" (4 items: "disturbance of organs",

"physical illness", "body is not in harmony", "problems of nerves"), factor 6 "broken taboos" (4 items: "contact with something taboo", "contact with something polluted", "failure of rituals after birth", "something wrong during pregnancy") and factor 7 "burden" (4 items: "hereditary determined", "conflicts in family", "aggressive feelings of others", "bad events during childhood"). Cronbach's α values for reliability were between 0.54 and 0.68.

Comparison of explanatory models of patients with schizophrenia and obsessive-compulsive disorder from Austria and Pakistan. Scrutinizing first the distributions of explanatory dimensions in the single patient groups, Austrian patients with schizophrenia showed wide ranges of "rational" explanatory models like "stress", "life-events", "somatic illness" and "burden" (table 3).

The Austrian OCD-sample presented also high mean values for "stress" (lower than the schizophrenic subjects), "somatic illness" and "burden". Other possible reasons like personal "guilt" or "magic" were less important for the Austrian OCD-patients than for the Austrian patients with schizophrenia.

Like Austrian patients with schizophrenia, Pakistani schizophrenics showed a wider range of possible explanations than the OCD-patients. But also significant differences concerning the single dimensions were found in Pakistan: patients with schizophrenia more often thought that "life events" or a "burden" from the past were responsible for their illness.

Comparing the distribution of the single explanatory dimensions within the four patient groups, "magic" showed the highest means within the Pakistani sample, independent from the type of illness. "Rational" explanations ("stress", "somatic illness", and "burden") were seldom used by Pakistani subjects. "Life-events" in both countries were more important as causal models for schizophrenic subjects than for the OCD-patients. "Stress", "somatic illness" and "burden" were typical Austrian explanations.

DISCUSSION

The investigation of patients' beliefs about the causes of their mental illness by use of the CEMD provided a seven factor structure of the respondents' explanatory models. The scales of the CEMD (table 2) were in some way different from those Eisenbruch (1990) found by use of a similar questionnaire: The possible causes of mental disorders aggregate into four major groups along two dimensions: "Western physiology", "Non-Western physiology", "Stress", and "Mystical". Beside of the choice of different statistical procedures, the most important reason for these differences may be the composition of samples: while our questionnaire was applied to mentally ill patients asking them about the possible reasons of their own problems, Eisenbruch (1990) has asked healthy students about their cognitive representations of the causes of mental illnesses in general. In our setting, many of the relatively clear distinctions proposed by anthropologists (Murdock et al. 1978) may become blurred, because the patients' explanations for their illness have additionally been influenced by the illness process. The reliability of our scales (table 2) was between average and satisfying (Cronbachs α: 0.59-0.68), depicting the nosological and cultural heterogeneity of the samples under investigation.

It became obvious that, independent of cultural origins, OCD-patients showed more distinct patterns of possible explanations of their illness compared with schizophrenic subjects: OCD patients in Austria suppose primarily rational reasons as responsible for their problems. In contrast, Pakistani patients with OCD believe that magic or bad dreams are the relevant causes for their disturbance, while the belief that infringement of social or cultural rules ("breaking taboos") seems to be important for Pakistani patients with schizophrenia.

Schizophrenic patients in both cultures seem to be more insecure about the real causes of their illness: they do not really exclude any possible explanation. In contrast to the Austrian OCD patients, for the schizophrenic subjects "magic" or personal "guilt" are thinkable reasons too. In this case a clear distinction between delusions of guilt and religion on the one side and culturally derived cognitive representations on the other is not possible. For Pakistani patients the result is quite similar: Pakistani patients with schizophrenia also believe that a wider range of reasons like life-events or somatic agents might be responsible for their illness compared with the OCD patients. Beside of the above mentioned influence of delusions on the statements of the schizophrenic group, cognitive deficits may be responsible for the vagueness of their explanations.

There is a general tendency in Pakistani patients to accuse supernatural forces like bad spirits as the most important cause of disease, depicting the central position of these beliefs of popular Islam in Pakistan (Fremdgen 1990), whereas Austrian patients in general think that stress may be contribute to their illness. This may also have to do with the fact that Austrian patients are more often employed than the Pakistanis (table 1).

Explanatory models of mental illness are multidimensional constructs primarily derived from culture, but also influenced by disease-specific features.

REFERENCES

Bhugra D. Attitudes towards mental illness: A review of the literature. Acta Psychiatr Scand 1989;80:1-12.

Edergton RB. Conceptions of psychosis in four East African societies. Am Anthropologist 1966;68:408-425.

Edman JL, Koon TY. Mental illness beliefs in Malaysia: Ethnic and intergenerational comparisons. Int J Soc Psychiatry 2000;46:101-109.

Eisenbruch M. Classification of natural and supernatural causes of mental distress. Development of a mental distress explanatory model questionnaire. J Nerv Ment Dis 1990;178:712-719.

Eskin M. Rural population's opinions about the causes of mental illness, modern psychiatric help-sources and traditional healers in Turkey. Int J Soc Psychiatry 1989;35:324-328.

Foster GM. Disease etiologies in non-western medical systems. Am Anthropol 1976;78:773-776.

Frances A., First MB, Pincus HA. DSM-IV Guidebook. Washington London: American Psychiatric Press, Inc 1995.

Fremdgen J. Alltagsverhalten in Pakistan. Rieden am Vorggensee: Mundo 1990.

Ilechukwu ST. Inter-relationship of beliefs about mental illness, psychiatric diagnoses and mental health care delivery among Africans. Int J Soc Psychiatry 1988;34:200-206.

Kleinman A. Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine and psychiatry. Berkeley: University of California Press 1980.

Kohl F.-S. Représentations étiologiques de la maladie mentale chez les patients schizophènes et leurs soignants. Unpublished manuscript.

Kulhara P, Avasthi A, Shamara A. Magico-religious beliefs in schizophrenia: A study from North India. Psychopathology 2000;33:62-68.

Murdock GP, Wilson SF, Frederick V. Cultural illness and health. Anthropolgical studies (no 9). Washington, DC: American Anthropological Association 1978.

Patel V. Explanatory models of mental illness in Sub-Saharan Africa. Soc Sci Med 1995;40:1291-1298.

Weiss MG, Raguram R, Channabasavanna SM. Cultural dimensions of psychiatric diagnosis. A comparison of DSM-III-R and illness explanatory models in South India. Brit J Psychiatry 1995;166:353-359.

Westermeyer J, Wintrob R. "Folk" explanations of mental illness in rural Laos. Am J Psychiatry 1979;136:901-905.

Table 1. Sample characteristics of patients with schizophrenia and obsessive-compulsive disorder (OCD) in Austria and Pakistan

Sample	Sex	Age	Confession	Marital status	Actual Employed
Schizophrenia Austria (N = 125)	84 m 41 f	37.7 (± 11.1)	No confession: 21 (16.8%) Roman-catholic: 93 (74.4%) Protestant: 9 (7.2%) Others: 2 (1.6%)	Married: 11 (8.8%) Single: 99 (79.2%) Divorced: 14 (11.2%) Widowed: 1 (0.8%)	63 (50.4%)
OCD Austria (N=58)	32 m 26 f	36.7 (± 11.1)	No confession: 21 (36.2%) Roman-catholic: 32 (55.2%) Protestant: 3 (5.2%) Others: 2 (3.4%)	Married: 19 (32.8%) Single: 34 (58.6%) Divorced: 5 (8.6%) Widowed: 0	37 (63.8%)
Schizophrenia Pakistan (N=120)	89 m 31 f	34.3 (± 10.4)	Sunnitic: 118 (98.3%) Roman-catholic: 2 (1.7%)	Married: 30 (25.0%) Single: 84 (70.0%) Divorced: 5 (4.2%) Widowed: 1 (0.8%)	39 (32.5%)
OCD Pakistan (N=70)	36 m 34 f	26.9 (± 7.0)	Sunnitic: 70 (100.0%)	Married: 38 (54.3%) Single: 32 (45.7%) Divorced: 0 Widowed: 0	31 (44.3%)

Table 2. Seven-factor model of illness concepts and their reliability

	Factor						
	1	2	3	4	5	6	7
	Magic	Life-event	Guilt	Stress	Somatic illness	Broken taboos	Burden
Bad or ominous dreams (Item 1)	.513						
Deliberate evil eye (Item 2)	.725						
Dangerous unprovoced spirit (Item 31)	.590						
Unwittingly casting an evil eye (Item 35)	.687						
Financial problems (Item 20)		.728					
Unemployment (Item 24)		.680					
Accident (Item 32)		.510					
Results of deeds and activities (Item 36)			.576				
Only a miracle can cure the illness (Item 39)			.613				
Sin against God (Item 40)			.498				
Overwork (Item 6)				.697			
Consequence of "modern life" (Item 8)				.717			
Disturbance of organs (Item 5)					.595		
Physical illness (Item 15)					.672		
Body is not in harmony (Item 16)					.539		
Problem of nerves (Item 21)					.544		
Contact with something taboo (Item 9)						.429	
Contact with something polluted (Item 11)						.493	
Failure of rituals after birth (Item 26)						.593	
Something wrong during pregnancy (Item 38)						.609	
Hereditary determined (Item 7)							.640
Conflicts (Item 14)							.641
Aggressive feelings of others (Item 27)							.492
Bad events during childhood (Item 29)							.416
Eigenvalue after rotation (Varimax)	2.89	2.29	2.19	2.16	2.09	2.04	2.02
Cronbach's α	.68	.65	.59	.59	.62	.54	.65

Table 3. Test of culture- and disease specific differences in illness concepts (weighted means of explanatory dimensions) of patients with schizophrenia and obsessive-compulsive disorder in Austria and in Pakistan

Dimension	Schizophrenia (Austria)	OCD (Austria)	Schizophrenia (Pakistan)	OCD (Pakistan)	F - Value	P
Magic	1.18 [a]	1.04	1.37 [b]	1.38 [b]	23.8	.000
Life-events	1.33 [b]	1.06	1.24 [a]	1.13	16.4	.000
Guilt	1.40 [a]	1.21	1.29	1.28	6.7	.000
Stress	1.56 [b]	1.43 [a]	1.26	1.19	19.6	.000
Somatic illness	1.49 [b]	1.44 [b]	1.35 [a]	1.25	12.4	.000
Broken taboos	1.17	1.10	1.27 [a]	1.16	8.7	.000
Burden	1.56 [a]	1.54 [a]	1.37	1.31	15.3	.000

One-way ANOVA (+ Duncan post-hoc test); [a] significant difference to non-marked means; [b] significant difference to means marked with [a]

Appendix

		Yes, very likely	Probably yes	Rather not	Not likely at all
1.	My difficulties appeare as a consequence of bad dreams.				
2.	My problems are due to the evil eye.				
3.	My illness results from my having done something forbidden.				
4.	My problems were caused by bad luck.				
5.	My problems originate from disturbances of one or more organs or functions.				
6.	My problems result from overwork.				
7.	My illness is hereditary or genetically determined.				
8.	My problems are a consequence of hectic modern life.				
9.	I got this illness because I touched upon something which I had better left alone.				
10.	All that has occurred to me is is the result of divine inter-vention.				
11.	I got my illness because I touched something polluted.				
12.	I fell ill because the humours of my body got confused.				
13.	My problems are due to an infection.				
14.	My illness results from conflicts with my family or my social environment.				
15.	My illness is a somatic one.				
16.	I feel ill because my body and its components were no longer in harmony.				
17.	I got my problems because I saw or heard something extraordinary.				
18.	My difficulties result from disturbances of the chemical equilibrium of my brain.				
19.	I got these problems because I had moved from one country to another.				
20.	I fell ill because I had financial problems.				
21.	My illness is a problem of the nerves.				
22.	I fell ill because I ate forbidden food.				
23.	I got my illness because of old age.				
24.	I fell ill because I was unemployed.				
25.	My problems originated from a sensation of heat within my body.				
26.	My illness occurred because my parents had failed to observe certain birth rites.				
27.	My illness is a consequence of the aggressive feelings of certain other people.				
28.	My difficulties result from the death of a beloved person.				
29.	My difficulties originate from events in my childhood.				
30.	My problems stem from a brain damage.				
31.	I think I am ill because an evil spirit has taken control over me.				
32.	My problems started after an accident.				
33.	My difficulties result from an emotional shock or a bad experience.				
34.	My problems are due to an unfortunate constellation of the stars.				
35.	I got my problems because I had accidentally been exposed to the evil eye.				
36.	My illness is the result of my deeds and activities.				
37.	All that originates from the break of a love affair.				
38.	My illness occurred because something wrong or evil had been during pregnancy of my mother.				
39.	Only a miracle can cure me from my illness.				
40.	I am ill because I have sinned against God.				
41.	Prayers may contribute to my recovery.				

Cultural Sensitivity in Psychiatric Diagnosis

Johannes G.B.M. Rohlof, M.D.
Centrum ’45, the Netherlands

Cultural problems in many fields

- Diagnostics: for instance misdiagnostics of psychotic features
- Treatment: for instance difficulty to change from passive treatment to more active
- Communication: help seeking behaviour differs from one culture to another.

Culture and Trauma
Diagnostics

- tabu items stay behind (e.g. rape)
- externalising vs internalising behaviour
- absence of mourning rituals
- content nightmares can enhance fear (spirits, ancestors)
- more somatic complaints

Culture and Trauma
Treatment

- Testimony method as identity change
- Sweat lodge as example of culture sensitive treatment
- Dealing with native healers
- Psychotherapy with interpreters

Culture and Trauma
Communication

- Wrong/right as western thinking
- Talking or keeping silence about traumatic experiences
- Society could be constructed (western) against curves of history

Cultural formulation of DSM-IV

- Cultural identity of the individual
- Cultural explanations of the disease by the individual
- Cultural factors in psychosocial environment and in functioning
- Cultural elements in the relation between the individual and the practitioner

1. Cultural identity

- Cultural reference group, language abilities, use
- Conflictuous identity

2.Cultural explanations of ilness

- Own illness description, explanation
- experienced severity of complaints
- local illness category
- causes or explanatory models
- current preferences for and past experiences with professional and popular sources of care

3. Environment/functioning

- Culturally relevant interpretations of social stressors
- Culturally relevant available social supports
- Culturally relevant levels of functioning

4. Cultural elements of the relationship individual-clinician

- differences in culture and social status
- following problems in diagnosis and treatment (e.g. language use, cultural significance of symptoms, level of intimacy, determining of pathology)

Pilot study in Centrum ’45

Aim: getting experience with doing interviews for cultural formulation and knowing better practical problems in interview

- Purpose group: 20 patients who are able to reflect on their cultural background
- Method: semi-structured interview of 40 questions before the start of treatment
- Duration: with interpreter: 1 till 1 ½ hour
- Written report

Pitfalls in the interview

- To what extent is the interview structured?
- How to compare with culture of origin; and what is the calibration point?
- More information from culture of origin is needed
- Cluster 4 could not be asked for
- Who can interview? How much education?

Conclusions

- Cultural interview is feasible and informative
- Format of cultural information is helpful
- Standard cultural interview in beginning of therapy is good starting-point for therapy with cultural different patients.
- But cultural differences need to be looked for till the end of treatment

ETHNIC AND GENDER DIFFERENCES IN MENTAL ILLHEALTH

G. Mustafa Soomro*
Sara Arber**

*Community Psychiatry, St. George's Hospital Medical School, London,
**Department of Sociology, University of Surrey

Email: g.msutafa.soomro@which.net

ABSTRACT

Background and aims:
Ethnic and gender differences in mental ill health remain inadequately researched. This study aims at investigating rates of five mental ill health conditions, namely alcoholism, anxiety, depression, mania and psychotic symptoms between five ethnic groups (i.e. whites, Caribbeans, Indians or African Asians, Pakistanis or Bangladeshis and Chinese) and between men and women. This study also aims to investigate socio-economic explanatory variables of age, employment status, marital status and social class within men and women separately by using logistic regression with particular aim of finding out effect of these variables on relationship of ethnic groups with mental ill health conditions. However it also explores the relationship of all the five independent variables (i.e. ethnicity, age, employment status, marital status and social class) within men and women separately to find out what variables relate to the five mental ill health conditions and thus how they differ between men and women.

Methods
The study uses the Policy Studies Institute's Fourth National Survey of Ethnic Minorities dataset to investigate the above issues. Thus this study essentially is a secondary analysis study of cross-sectional survey data. The samples consisted of randomly selected representative samples about 5000 white people and about 2500 ethnic minority people. Statistical methods used are, crosstabulation and chi square test and logistic regression.

Results and conclusions
The main findings are as follows. Alcoholism, anxiety and depression are more common in whites than ethnic minorities. The rates of mania and psychotic symptoms are higher in Caribbeans than the other groups – but the rate for psychotic symptoms in comparison to the other ethnic groups is not as high as previously reported. Age, employment status, marital status and social class do not influence and explain differences in odds ratios across the ethnic groups in all the five mental ill health conditions.
Social class mostly is not related to mental ill health both in men and women when all the independent variables are taken into account. However age, employment status and marital status are related to anxiety, depression and psychotic symptoms in men, and to alcoholism, anxiety, depression and psychotic symptoms in women (when all the independent variables are taken into account). Mania does not seem to be related to these four variables (except ethnic group).

INTRODUCTION

The issues of prevalence and associated factors of mental ill-health for various ethnic groups and for genders remain inadequately researched. Most of the previous research is characterised by significant methodological problems - such as problems with definitions of variables and selective or biased sampling. [1]

This study investigates prevalence and the associated factors for alcoholism, anxiety, depression, mania and psychotic symptoms through secondary data analysis of a nationally representative dataset i.e. Fourth National Survey of Ethnic Minorities in England and Wales (the survey was carried out during 1993 and 1994). [2] [3] This analysis was carried out for prevalence rates of mental ill-health conditions for various ethnic groups, for men and women within the ethnic groups and also for the factors associated with these mental ill-health conditions in different ethnic groups and in men and women. The definition of the mental ill-health categories used are broad and are such that they would cover both prevalence of clinical and sub-clinical morbidity.

Nazroo (1997) [4] also has analysed this dataset but using narrower definitions of anxiety depression and psychosis. He did not investigate associated factors for anxiety and associated factors for men and women separately. He also did not investigate alcoholism and mania.

METHODS

The sample for the Fourth National Survey of Ethnic Minorities in England and Wales consisted of nationally representative random sample of over 5000 people of ethnic minority origin and of about 2500 white people and was selected using multistage probabilistic sampling method. The aim of the original survey was to collect data, which would allow comparison of socio-economic conditions and health of the main ethnic minority groups with the white majority. This study used methodology of secondary data analysis of the survey dataset to investigate the questions interest. For this investigation statistical methods/tests used were cross-tabulation and chi-square test and logistic regression. Analysis was carried out after weighting the dataset to compensate for non-response and deviations from the census data.[3]

Definitions of dependent variables

The data on dependent variables were collected using Clinical Interview Schedule-Revised (CIS-R) [5][4] and Psychosis Screening Questionnaire (PSQ) [4]. For the purpose of this analysis dependent variables are defined as follows. ***Anxiety*** is defined as 'feeling anxious or nervous', or 'feeling tension and being unable to relax', or 'having phobic anxiety' during the last month. ***Alcoholism*** is defined as excessive drinking which leads to having shakes and or drinking in the morning. ***Depression*** is defined as being sad or having anhedonia (loss of interest or enjoyment) during the last month and also during the last week – thus it continual sadness or anhedonia or both over the last month. ***Mania*** is defined as feeling very happy for days on end without a break, which in the judgement of relatives was strange or gave them a reason to complain about it. ***Psychotic symptom(s)*** are defined as having any of the following symptoms: delusional mood, hallucinations or thought interference.

Definitions of some of the independent variables

The variable ***'ethnic'*** within the dataset essentially consists of White, Caribbean, Indian, African Asian, Pakistani, Bangladeshi and Chinese. The country of origin of the family was used primarily to develop this variable. For this analysis Indian and African Asians; and Pakistanis and Bangladeshis were combined into single categories respectively. ***Social class*** is defined using the Registrar General's classification. The category of 'missing on social class' included students, housewives who had never worked, armed forces and those not working for other reasons. Categories for ***age group, employment status and marital status*** were created as shown in tables 5 and 6.

RESULTS

Prevalence rates

Ethnic differences

Alcoholism, anxiety and depression are more common in whites than ethnic minorities (later as a combined group) (4% versus 1.4%, 37.8% versus 25.9% and 19.4% versus 16.2% respectively), but they do not differ significantly on mania and psychotic symptoms (see table 1).

However when whites and different minority groups are compared all five mental ill-health conditions significantly differ between the comparison groups (see table 2) and all such difference holds true for the groups within women, but only for alcoholism, anxiety and depression within men (see table 3). Of note are higher rates for Caribbean women for mania (3.8% as compared to 1.2% in white women) and for psychosis (13.3% as compared to 4% in white women).

Gender differences

Alcoholism is significantly more common in men within whites and Caribbeans – whereas its rates are not different between men and women in Indians or African Asians and Pakistanis or Bangladeshis and Chinese. Anxiety and depression is significantly more common in women in whites, Caribbeans and Indians or African Indians – whereas it is not different between men and women in the other two groups. Mania is not significantly different between men and women in any of the groups. Psychotic symptoms are significantly more common in Caribbeans women than in Caribbean men – in rest of the groups the rate between men and women are similar (see table 4).

Results of logistic regression

(See tables 5 and 6)

Ethnic differences

Odds ratio for alcoholism and anxiety is lower in Asian groups and Caribbeans both in men and women than their white counterparts. Odds ratio for depression in Caribbeans is higher in both men and women and lower in other ethnic minority groups both in men and women than their white counter parts. Odds ratio for mania is higher in Caribbeans women and lower in Asian groups both in women and men than their white counter parts. Odds ratio for psychotic symptoms is higher in Caribbean women (and also non-significantly in Caribbean men) and lower in Asian groups both in men and women than their white counterparts.

Age, employment status, marital status and social class do not influence and explain odds for any of the conditions (i.e. alcoholism, anxiety, depression, mania and psychotic symptoms) across ethnic groups.

Gender differences

The following results are obtained in relation to each condition in men and women, when ethnic group, age group, employment status, marital status and social class are simultaneously controlled.

Alcoholism in men is not related to age, employment status, marital status and social class. But in women it is related to employment status, marital status and social class - with those in full time education or training, unemployed, and single showing higher odds and those missing on social class (e.g. housewives) showing lower odds for alcoholism.

Anxiety in men is related to employment status and social class with those in full time education or training, sick or disabled and unemployed showing higher odds and those who are lower social classes and missing on social class showing lower odds for anxiety. Whereas in women it is related to employment status and marital status with those who are sick or disabled, unemployed and separated, divorced or widowed showing significantly higher odds of anxiety.

Depression in men is related to age group, employment status, marital status with men aged 25-34 and 45-54, in full time education or training, sick or disabled, unemployed and separated, divorced or widowed showing significantly higher odds for depression. Depression in women is related to employment status and marital status with sick or disabled, unemployed and separated, divorced or widowed showing higher odds.

Mania in men is associated with social class only, with social class III showing significantly lower odds. Mania in women is not related to age group, employment status, marital status and social class.

Psychotic symptoms in men are related to age group, employment status and marital status. Men of all five age groups of 25-34 and above show lower odds and those who are sick or disabled, others not in job and separated, divorced or widowed show higher odds for psychotic symptoms. Psychotic symptoms in women are related to employment status, marital status and social class, with those who are unemployed, separated, divorced or widowed and social class III showing higher odds for psychotic symptoms.

Table 1: Mental ill health among whites and ethnic minorities

Symptoms	**White population**	**Ethnic minorities**	**Sig.**
Alcoholism	115/2751 (4.0%)	37/2530 (1.4%)	Chi square = 33.01 P <.001
Anxiety	1080/2861 (37.8%)	664/2565 (25.9%)	Chi square = 87.44 P <.001
Depression	557/2867 (19.4%)	416/2574 (16.2%)	Chi square = 9.90 P <.01
Mania	38/2815 (1.3%)	75/5093 (1.4%)	Chi square = 0.13 P = 0.71
Psychotic symptom(s)	131/2724 (4.6%)	260/4931 (5%)	Chi square = 0.73 P = 0.39

Table 2: Mental health among whites and different ethnic minority groups

Symptom(s)	White population	Caribbeans	Indians or African Asians	Pakistanis or Bangladeshis	Chinese	Sig.
Alcoholism	115/2751(4.0%)	21/782 (2.7%)	14/1034 (1.3%)	2/556 (0.4%)	0/195 (0%)	Chi square = 41.17 P < .001
Anxiety	1080/2861 (37.8%)	265/781 (34%)	245/1031 (23.8%)	103/558 (18.5%)	50/195 (25.5%)	Chi square = 126.949 P < .001
Depression	557/2867 (19.4%)	196/783 (25%)	127/1037 (12.3%)	62/558 (11.1%)	31/195 (15.7%)	Chi square = 72.47 P < .001
Mania	38/2853 (1.3%)	49/1558 (3.1%)	18/2079 (.9%)	5/1140 (.4%)	3/391 (.7%)	Chi square = 47.06 P < .001
Psychotic symptom(s)	131/2855 (4.6%)	161/1560 (10.3%)	65/2081 (3.1%)	29/1142 (2.6%)	5/391 (1.2%)	Chi square = 138.24 P < .001

Table 3: Mental health among whites and different ethnic minority groups by sex

Symptoms	Males					Sig.	Females					Sig.
	Whites	**Caribb-eans**	**Indians or African Asians**	**Pakis-tanis or Bangla-deshis**	**Chinese**		Whites	**Caribb-eans**	**Indians or African Asians**	**Pakis-tanis or Bangla-deshis**	**Chinese**	
Alcohol	70/1276 (5.5%)	14/355 (3.9%)	8/495 (1.7%)	2/289 (2%)	0/108 (0%)	Chi sq.= 27.96 P<.001	45/1590 (2.8%)	7/426 (1.6%)	5/540 (1%)	0/268 (0%)	0/87 (0%)	Chi sq.= 15.95 P<.01
Anxiety	426/1275 (33.4%)	100/355 (28.2%)	103/493 (20.9%)	50/289 (17.4%)	27/108 (25.4%)	Chi sq.= 47.36 P<.001	654/1586 (41.2%)	165/425 (38.9%)	142/538 (26.4%)	53/268 (19.7%)	22/87 (25.7%)	Chi sq.= 76.83 P<.001
Depression	207/1276 (16.2%)	72/355 (20.2%)	48/495 (9.7%)	36/290 (12.4%)	15/108 (14.2%)	Chi sq.= 21.61 P<.001	350/1591 (22%)	124/428 (29.1%)	79/542 (14.6%)	26/268 (9.7%)	15/87 (17.6%)	Chi sq.= 52.99 P<.001
Mania	20/ 1271 (1.6%)	17/702 (2.4%)	10/1040 (1%)	4/593 (0.6%)	3/185 (1.4%)	Chi sq.= 8.73 P=.07	18/1582 (1.2%)	32/856 (3.8%)	8/1039 (0.7%)	1/548 (0.3%)	0/206 (0%)	Chi sq.= 46.75 P<.001
Psychotic symptom(s)	67/1272 (5.3%)	47/703 (6.7%)	36/1042 (3.4%)	17/593 (2.9%)	4/185 (4.9%)	Chi sq.= 19.05 P<.01	64/1583 (4%)	114/856 (13.3%)	29/1039 (2.8%)	12/549 (2.2%)	1/206 (.6%)	Chi sq.= 148.30 P<.001

Table 4: Gender differences in mental ill health among ethnic minority group

Symp-toms	**Whites**			**Caribbeans**			**Indians or African Asians**			**Pakistanis or Bangladeshis**			**Chinese**		
	Males	**Females**	**Sig.**	**Males**	**Fe-males**	**Sig.**	**Males**	**Female s**	**Sig.**	**Males**	**Fe-males**	**Sig.**	**Males**	**Fe-males**	**Sig.**
Alcohol	70/1276 (5.5%)	45/1590 (2.8%)	Chi sq= 13.45 P <.001	14/355 (3.9%)	7/426 (1.6%)	Chi sq.= 3.89 P<.05	8/495 (1.7%)	5/540 (1%)	Chi sq.= 1.01 P=.32	2/289 (.8%)	0/268 (0%)	Chi sq.= 2.08 P = .15	0/108	0/87	Chi sq.= P
Anxiety	426/1275 (33.4%)	654/1586 (41.2%)	Chi sq= 18.35 P <.001	100/355 (28.2%)	165/425 (38.9%)	Chi sq.= 9.80 P<.001	103/493 (20.9%)	142/538 (26.4%)	Chi sq.= 4.33 P<.05	50/289 (17.4%)	53/268 (19.7%)	Chi sq.= .50 P= .48	27/108 (25.4%)	22/87 (25.7%)	Chi sq.= .002 P=.95
Dep-ression	207/1276 (16.2%)	350/1591 (22%)	Chi sq.= 15.10 P<.001	72/355 (20.2%)	124/428 (29.1%)	Chi sq.= 8.15 P<.001	48/495 (9.7%)	79/542 (14.6%)	Chi sq.= 5.88 P<.05	36/290 (12.4%)	26/268 (9.7%)	Chi sq.= 1.10 P=.30	15/108 (14.2%)	15/87 (17.6%)	Chi sq.= .42 P=.52
Mania	20/ 1271 (1.6%)	18/1582 (1.2%)	Chi sq= .93 P =.33	17/702 (2.4%)	32/856 (3.8%)	Chi sq.= 2.61 P=.15	10/1040 (1%)	8/1039 (0.7%)	Chi sq.= .37 P=.54	4/593 (0.6%)	1/548 (0.3%)	Chi sq.= 8.4 P=.35	3/185 (1.4%)	0/206 (0%)	Chi sq.= 3.00 P=.08
Psych-otic symp tom(s)	67/1272 (5.3%)	64/1583 (4%)	Chi sq.= 2.54 P= .11	47/703 (6.7%)	114/856 (13.3%)	Chi sq.= 17.92 P<.001	36/1042 (3.4%)	29/1039 (2.8%)	Chi sq.= .58 P=.45	17/593 (2.9%)	12/549 (2.2%)	Chi sq.= .61 P=.43	4/185 (4.9%)	1/206 (.6%)	Chi sq.= 1.50 P=.22

Table 5: Logistic regression - odds ratio for Alcoholism, Anxiety and Depression

	Alcoholism				**Anxiety**				**Depression**			
	Men		**Women**		**Men**		**Women**		**Men**		**Women**	
	Model A	**Model B**	**Model A**	**Model B**	**Model A**	**Model B**	**Model A**	**Model B**	**Model A**	**Model B**	**Model A**	**Model B**
Ethnic group	+++	+++	++	+	+++	+++	+++	+++	+++	+++	+++	+++
White	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Caribbean	0.60	0.55	0.41*	0.32**	0.73*	0.71*	0.83	0.75*	1.30	1.19	1.48**	1.32*
Indian or African Asian	0.25***	0.28***	0.23**	0.30*	0.48***	0.48***	0.46***	0.47***	0.54***	0.50***	0.60***	0.60***
Pakistani or Bangladeshi	0.10***	0.11**	#	#	0.37***	0.34***	0.31***	0.35***	0.76	0.58**	0.38***	0.38***
Chinese	0.001	0.001	#	#	0.61*	0.65	0.43***	0.38***	0.84	0.89	0.75	0.66
Age group	++	NS	+++	NS	+++	NS	+++	NS	+	+	NS	NS
16-24	1.00		1.00		1.00		1.00		1.00	1.00		
25-34	0.79		0.30***		0.81		1.02		1.51*	1.65*		
35-44	0.63		0.13***		0.72*		1.02		1.44	1.40		
45-54	0.48*		0.20***		0.86		0.91		1.91***	1.76*		
55-64	0.33*		#		0.71*		0.73*		1.18	0.91		
65 or above	0.40**		0.05***		0.41***		0.55***		1.18	1.25		
Employment status		NS		+		+++		+++		+++		+++
Employed				1.00		1.00		1.00		1.00		1.00
F/T education or training				2.59*		1.57*		1.35		2.28**		1.25
Sick or disabled				0.97		4.11***		3.85***		4.67***		4.14***
Retired				0.36		1.03		0.90		1.11		0.98
Unemployed				3.28**		2.39***		1.78**		2.80***		2.15***
Others not in job				0.90		2.19		1.09		1.43		1.18
Marital status		NS		++		NS		+++		+		+++
Married				1.00				1.00		1.00		1.00
Separated or divorced or widowed				1.52				1.63***		1.60*		1.63***
Single				3.56**				1.17		0.77		1.20
Social class		NS		++		+++		NS		NS		NS
I & II				1.00		1.00						
III				0.82		0.56***						
IV & V				0.52		0.53***						
Missing on social class				0.11***		0.49***						
Model LLR	739	719	479	439	2913	2827	3679	3617	2095	2016	2890	2826
Delta LLR from null model	70	90	82	122	78	165	107	169	37	116	62	125
Delta df from null model	9	19	9	19	9	19	9	19	9	19	9	19
N=	3746		4317		3746		4317		3746		4317	

+ significance of variable in the model: + P<0.05, ++ P<0.01, +++ P< 0.001; * significance of difference from the reference category: *P< 0.05, **P<0.01, ***P<0.001
NS = non-significant; # Odds ratios cannot be calculated because there are no cases for these sub-groups

Table 6: Logistic regression - odds ratio for Mania and Psychotic symptoms

	Mania				**Psychotic symptoms**			
	Men		**Women**		**Men**		**Women**	
	Model A	**Model B**	**Model A**	**Model B**	**Model A**	**Model B**	**Model A**	**Model B**
Ethnic group	NS	+	+++	+++	+++	++	+++	+++
White		1.00	1.00	1.00	1.00	1.00	1.00	1.00
Caribbean		1.30	2.83***	2.81**	1.20	1.20	3.38***	3.10***
Indian or African Asian		0.49	0.54	0.53	0.57**	0.61*	0.65	0.66
Pakistani or Bangladeshi		0.27*	0.17*	0.14*	0.46**	0.44**	0.48*	0.48*
Chinese		0.68	#	#	0.30*	0.37	0.13*	0.12*
Age group	NS	NS	NS	NS	+	+++	NS	NS
16-24					1.00	1.00		
25-34					0.83	0.55*		
35-44					0.84	0.48*		
45-54					0.58*	0.30***		
55-64					0.47*	0.18***		
65 or above					0.37**	0.23*		
Employment status		NS		NS		+++		+++
Employed						1.00		1.00
F/T education or training						0.71		1.64
Sick or disabled						5.12***		3.90***
Retired						1.03		1.10
Unemployed						1.32		1.70*
Others not in job						3.93*		1.18
Marital status		NS		NS		+		+++
Married						1.00		1.00
Separated or divorced or widowed						2.06*		2.16***
Single						0.72		1.23
Social class		++		NS		NS		+
I & II		1.00						1.00
III		0.38*						1.79*
IV & V		0.84						1.18
Missing on social class		2.28						1.32
Model LLR	539	520	576	563	1360	1318	1598	1555
Delta LLR from null model	20	41	54	67	34	76	132	176
Delta df from null model	9	19	9	19	9	19	9	19
N=	3746		4317		3746		4317	

+ significance of variable in the model: + P<0.05, ++ P<0.01, +++ P< 0.001; * significance of difference from the reference category: *P< 0.05, **P<0.01, ***P<0.001
NS = non-significant; # Odds ratios cannot be calculated because there are no cases for these sub-groups

DISCUSSION

The mental ill health conditions investigated in this study (i.e. alcoholism, anxiety, depression, mania and psychotic symptoms) represent both clinical and sub-clinical morbidity as broader definitions are used in this study. Thus the prevalence rates obtained here may be higher than reported by the studies, which have used clinical diagnostic criteria. Sub-clinical morbidity deserves to be investigated seriously also (along with more usual focus on clinical morbidity), as in aggregate terms it accounts for more disability and economic costs to a population.[6] Thus research on sub-clinical morbidity has implications for public health education and prevention measures. The rates of mental ill health conditions found in this study are crude and not adjusted for age. Proportion of individuals of younger age groups is higher in ethnic minorities – thus the rates of this study for alcoholism, anxiety and psychotic symptoms (conditions more common in younger age) may be slightly inflated for ethnic minorities.

Lower rates for alcoholism in Indian and African Asians and Pakistanis and Bangladeshis (for both genders) may be explained by the cultural factors and complete absence of alcoholism in Chinese (for both genders) may be explained by biological intolerance to alcohol in this group.[7] Previous literature reports inconsistent rates for anxiety and depression for various ethnic groups. Thus comparing various studies in this area is problematic. This could be due to heterogeneity of studies carried out in this area.[1]

The rates of psychosis and mania found in this study are higher in Caribbeans than in any other group – but the rates for psychosis are much lower than up to thirty fold higher reported in the previous literature.[8] The previously reported much higher rates would appear to be due to methodological problems such as numerator and denominator problems, sampling strategies and possible diagnostic inaccuracies.[9]

One interesting finding of this study is that explanatory variables investigated in this study i.e. age, employment status, marital status and social class do not explain odds for any of the five conditions across all the ethnic groups. This may suggest that defining some of these putative explanatory across different ethnic groups (e.g. social class) may be problematic or that there may be differential effect of these characteristics across different ethnic groups. This also may mean that there may be other reasons for differences in the prevalence rates for example experience of discrimination (not investigated here) or different modes of expression of psychopathology in different groups (also not investigated in this study).

Alcoholism in men is not influenced by any of the explanatory factors (except ethnicity) reflecting strong influence of ethnic-cultural factor. However women who are in full time education/training, unemployed or single are at higher risk of alcoholism perhaps suggesting higher stress in these women. Men who are in full time education/training, sick or disabled, unemployed or in lower social classes show higher risk for anxiety. Women who are sick or disabled or unemployed also show higher risk for anxiety, whereas social class in women does not show a significant relationship. Separated or divorced or widowed women also show higher risk for anxiety whereas marital status is not significantly related to anxiety in men. Risk for

depression is explained by similar factors in both genders i.e. being in full time education/training and being separated or divorced or single. Thus being separated or divorced or single related to depression in men, but to both anxiety and depression in women, suggesting higher toll exerted by such situations in the latter.

Mania in both men and women is not explained by any of the explanatory variables (except ethnic group as described above). Risk for psychotic symptoms is related to similar employment and marital factors in both genders i.e. those sick or disabled, unemployed, or separated or divorced or single showing higher risk. Additionally men of age 25 and above show lower risk in comparison to younger men – a finding consistent with previous literature. Social class is not significantly associated with psychosis in this study and this may be due to adjustment of other variables or broader definition of psychosis (psychotic symptoms) used here.

Conclusions

The manifestations of mental ill health conditions of alcoholism, anxiety, depression, mania and psychotic symptoms broadly defined - thus covering both clinical and sub-clinical psychopathology - within various ethnic groups are as follows.

1. Alcoholism, anxiety and depression are more common in the white population than the ethnic minorities

2. Psychotic symptoms are about three times as common in Caribbean women as in their white counter parts. Although these are also higher in Caribbean men, but are not significantly different. This prevalence in Caribbean population is much lower than about up to 30 times reported previously.[8]

3. Age, employment status, marital status and social class do not influence and explains odds for any of the conditions (i.e. alcoholism, anxiety, depression, mania and psychotic symptoms) across ethnic groups.

4. In men age is related to depression and psychotic symptoms; employment status is related to anxiety, depression and psychotic symptoms; marital status is related to depression and psychotic symptoms; and social class is related to anxiety and mania.
In women employment status and marital status are related to alcoholism, anxiety, depression and psychotic symptoms and social class is related to alcoholism and psychotic symptoms.

REFERENCES

1. Soomro, G.M. (2001) Psychiatric morbidity and ethnic minority and white *population in the UK*, MSc Dissertation, University of Surrey UK
2. Modood, T., Berthoud, R., Lakey, J., Nazroo, J., Smith, P., Virdee, S. and Beishon, S. (1997) *Ethnic minorities in Britain*, London: Policy Studies Institute.
3. Smith, P. and Prior, G. (1996) *The Fourth National Survey of Ethnic Minorities Technical Report*, London: SCPR.
4. Nazroo, J. (1997) *Ethnicity and Mental Health*, London: Policy Studies Institute.
5. Lewis G, Pelosi AJ, Araya R, Dunn G. (1992) Measuring psychiatric disorder in the community: a standardized assessment for use by lay interviewers. Psychol Med. 1992 May;22(2):465-86.
6. Lewis, G. and Wessely, S. (1998) Neurosis and personality disorder. In: Murray, R., Hill, P. and McGuffin, P., (Eds.) *The Essentials of Postgraduate Psychiatry*, Third edn. Cambridge: Cambridge University Press

7. Luu, S.U., Wang, M.F., Lin, D.L., Kao, M.H., Chen, M.L., Chiang, C.H., Pai, L. and Yin, S.J. (1995) Ethanol and acetaldehyde metabolism in chinese with different aldehyde dehydrogenase-2 genotypes. *Proc Natl Sci Counc Repub China B* **19**, 129-136.
9. Sashidharan, S.P. and Francis, E. (1993) Epidemiology, ethnicity and schizophrenia. In: Ahmad, W.I.U., (Ed.) *'Race' and Health in Contemporary Britain*, Buckingham: Open University Press
8. Harrison, G., Owens, D., Holton, A., Neilson, D. and Boot, D. (1988) A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychol Med* **18**, 643-657.

TOLERENCE IN CROSS-CULTURAL SOCIETY

Johanna M. Tamm,
Pschiatrie und Psychotherapie FMH, Basel, Switzerland

Psychiatrie und Psychotherapie FMH
Riehenring 16, CH- 4058 Basel
Telefon 061 691 11 11
E-mail: **jmt@freesurf.ch**

INDEX

1) INTRODUCTION

The structure of human identity, the core of the personality, is race, language, religion and the practical approach to things implying ethics. The most delicate position is the personal philosophy towards religion, a “primum movens” in multilingual societies.

The interaction between society and the individual has changed dramatically since the current migration started.

On the one hand society, whereever, whichever, need a certain stability in order of function. On the other hand the identity, also of the new members, needs a chance to stay intact.

2) PROBLEM

Every society has higher values – a newcomer always has to adapt to. E.g. in Western Europe money and matter are not good enough. Those countries are so rooted in metaphysics that it appears as a shame to quarrel about fundamental religious opinions.

E.g. concerning Muslims: we do not say, we cannot deal with them when they need us, was just absolutely ask them to stay out of politics just like every other group.

Law and order has to be respected. This simple fact has become a historic achievment after the bad experiences of the initiators of World War II. This is history, integrated in people. Of course freedom is the highest value. It took a war of that size to teach a country part of the world.
Law and order are an asset, not a toy for political illiterates, let alone terrorists.

3) FACTS

On the individual level religion is very often the source of conflict. In this respect our situation, not only in the cities, most difficult moments with active Moslems. Classically, e.g.
if we look at the many people who left southern Italy, a country with a milder climate than our own, that they took the main problems, mainly Maffia-style of forgery etc. with them.
The same applies to people from the Balkan. Some of them imported e.g. the cruelty of the current drug scene etc. These are political and judicial problems. We can only help with forensic diagnostics.

The vast majority of immigrants work in the restaurants and building industries. There are only few animosities in every day life: religious freedom applies to them too.

The problem is by now in the numbers. Our countries are overcrowded anyhow.

4) INTERPRETATION

The point of language is clear. At home people can speak any language they like, but officially the immigrants have to speak the language of the country they choose. Religious rituals are considered private and personal.

The integrity, feelings of identity, of these people are never touched. This is the positive result of immigration policy these days.

History will show the result of this human globalisation.

The evolution will become fiendish only when the values of democracy and religious freedom are touched.

5) CONCLUSION

Western Europe, the current home with roots in the Judeo-Christian heritage, now a home to refugees, asylum seekers – haunted by totalitarian regimes, people who are motivated by economy etc. The legal bases are contradictory and partly confused.

The real trouble starts when those still foreign people cannot handle the stress any more, usually when religious differences escalate.

This is where we come in, because people feeling threatened in their identity do need help.

The age of enlightenment has given people the freedom to act rationally and unbiased.

Tolerance, freedom and truth as accepted values of higher order have had a political influence, first in the United States and Western Europe and were linked through a network of people who saw to freedom and ethics.

This is no doubt the basis why the current migration has the trend to these regions.

The International Organizations can and do protect these values to a certain degree. The influence of these organizations is often underestimated; and yet they help to protect the basic values.

Human beings do not seem to be able to live without religion in the long run. This is where tolerance has to be impeccable, even better than most constitutions ask for. Provocative manoeuvering including knowledge on how the world was created show a lack of responsibility: all these questions are by far too delicate, to be misused as emotional power.

There is no reason why the current mixture of people should not get more smooth in the long run. Agglomerations can be dangerous also in this respect.

Sometimes we wish the magnetic effect of our country would loosen. It is extremely costly for obvious reasons. e.g. the Italian South loses its very life, whereas we join concrete to no end.

The Nixonian question remains: do we really need all the people who come from Sri Lanka, etc. Do they really offer a type of work we are unable to cope with? Who gains, who loses?

6) EPILOGUE (INCLUDING SLIDES)

Unlike in times of migration people build their own culture in the regions they inhabit. Races who are migrant exist e.g. in the gypsies, some tribes of native Americans, the Massai in Africa etc.

If we try to understand the origin of religion and the rituals that go with it, in variations, we have to assume the people by and large seek their identity in culture in order to adopt a structure in their lives, as opposed to feel lost in a world void of an essay of understanding.

We shall of course never know whether the people created the Gods of vice versa " There are so many gods in this world and people have such a valid motivation also to know what is good, bad, or indifferent that is very well possible that people create metaphysical symbol they called gods as the ancient Greeks did.

I would like to illustrate this hypothesis in the framework of Central Europe, the region around the main massif of the Alps, virtually identical with today Switzerland.

Prehistory did, as far as we know, not leave any valid signs.

The Celts were there, in apparently partly dense populations. To them animals were so to speak religious equivalence to human beings. They did write and make a special point, that the dimension of time is unfathomable.

These successors came with Cajus Julius Caesar who turned the rocklike southern point of the "Knee" of the Rhine, his path of today's Basel, to his elevated point of his command.

There are impressive remnants of the Roman period ca. 20 km east of Basel, with Roman theatre, various buildings, silver ware, coins etc.

(Slide 1: Athena)

With Christianity moving in from the south as well a the north, from Ireland, the picture changed.

There were by no means only the medieval castles, mainly constructed for defence as virtually over all of Europe. There were a few monasteries of Carolingian times. In the southeastern part of Switzerland, in the mountainous region is Mustair (same word as monastery.) Mustair that could be restored with the help of UNESCO aid is in fact a rarity.

(Slides 2)3)4) Mustair Sta. Maria)

The contents of paintings of that period are always religous.

In the later middle ages churches with pointed towers, stained windows, funny figures and paintings with the golden background. Later the golden frame, meaning the infinite , turn up.

(Slide 5 Madonna)

Protestantism is by conviction much more modest. After the French revolution, that was partly directed against a church, turned feudalistic. Above all Austria and Bavaria were the only regions in Continental Europe that enabled development of Barock architecture as a representative of feudalism.

After all the religious wars in the 16th century people were convinced that peace is of higher value than welfare in the name of a religious denomination.

In today's multi religious world the personal psychological feelings of identity are of course still religious ones. But it is of paramount importance that all this stays out of politics. We are voting citizens, no more.

THE VALUE OF QUALITATIVE EVALUATION OF A CULTURAL CONSULTATION SERVICE

Danielle Groleau Ph.D.
Laurence Kirmayer M.D.
Caminee Blake Ph.D.

Division of Social and Transcultural Psychiatry
McGill University
&
Jewish General Hospital-SMBD

Institute of Community & Family Psychiatry
Jewish general Hospital - SMBD
4333 Côte-Ste-Catherine
Montréal, Québec H3T 1E2
Canada
Phone: (514) 340-8222 #3989 or #5655
Fax: (514) 340-7503
Email: **danielle.groleau@mcgill.ca**

ABSTRACT

The Cultural Consultation Service (CCS) at the Sir. Mortimer B. Davis-Jewish General Hospital in Montreal Québec was designed and implemented in 1999 expressively to improve accessibility and cultural appropriateness of mental health services. Populations targeted by the services include immigrants, refugees, ethnocultural groups and First Nations and Inuit as well as aboriginal peoples. Recent waves of migration and displacement of peoples by war and political upheaval have changed the demography of Canada, and present new challenges for mental health practitioners. The disciplines of cultural psychiatry and medical anthropology can provide expertise needed to adapt mental health services to the needs of our changing population. The research project discussed in this article adopted a participatory approach using participant-observation by the clinical coordinator, a consultant of the service and a research anthropologist working in close collaboration with the team. A protocol was developed for summarizing case conferences, cultural formulations and to address direct incidence for implementation of the new service. The specific goals of the qualitative evaluation were to: 1) document the process and guide the development and implementation of this new service; 2) identify the types of intercultural and systemic problems that motivated clinicians to use the service; 3) identify factors that facilitated and act as barriers to implementation of the service 4) identify a typology of Cultural Formulations that were produced by the service. A case will be presented to illustrate these issues. The process evaluation also helped to identify the usefulness and clinical relevance of the use of the DSM-4 Cultural Formulation tool. Certain criteria's need to be respected such as power given to participants, democracy, creativity, acceptance of multi-disciplinarily for this type of evaluation to take place. Although challenging, the main consequence of this evaluation, is that it can have spontaneous impact on development of the service.

OUTLINE

THE CULTURAL CONSULTATION SERVICE EVALUATION

- definition, objectives of evaluation , methodology, criteria,

RESULTS

- Frequent intervention problems
- Typology of cultural formulations (DSM-4)
- Implementation changes

CONCLUSION

- Culture as context
- Limits
- Future research

CULTURAL CONSULTATION SERVICE

Service implemented and evaluated at JGH (Health- Canada: FASS), the initial rational for implementing the service

- under utilization of mental health services by immigrants;
- cultural communities: problem of cultural adequacy of mental health services & fear of discrimination.

Process of CCS: regional service for clinicians

- Triage by clinical coordinator: clarify clinical problem and cultural reasons
- Referral to other organization or attribution of cultural-broker that interviews patient with DSM-IV *Cultural Formulation Tool*
- Case Conference with team and Cultural Broker:
    - Consultation reasons & presentation of everyone 's role and discussion of the cultural formulation presented by Cultural Broker
    - Negotiation & consensus on clinical recommendations produced by team
    - One page recommendations on the spot

Long version of cultural formulation and recommendations (two weeks)

PROCESS EVALUATION OF THE SERVICE: ONE OF THE QUALITATIVE COMPONENTS

Objectives of evaluation:

- Identify a typology of intercultural clinical problems
- Identify a typology of Cultural Formulations (DSM-IV) produced by the service
- Guide implementation of service

- Contributes to the validity of conclusions relative to the quantitative evaluation of the CCS
- Methodology: qualitative & participative approach
- Design: multiple case study with several levels of analysis (Yin, 1984): Cases: n=52
- Levels of analysis = different perspectives and explanations of actors participating to the implementation of the CCS

  N=all cases accepted after the triage during the 1.5 years of service

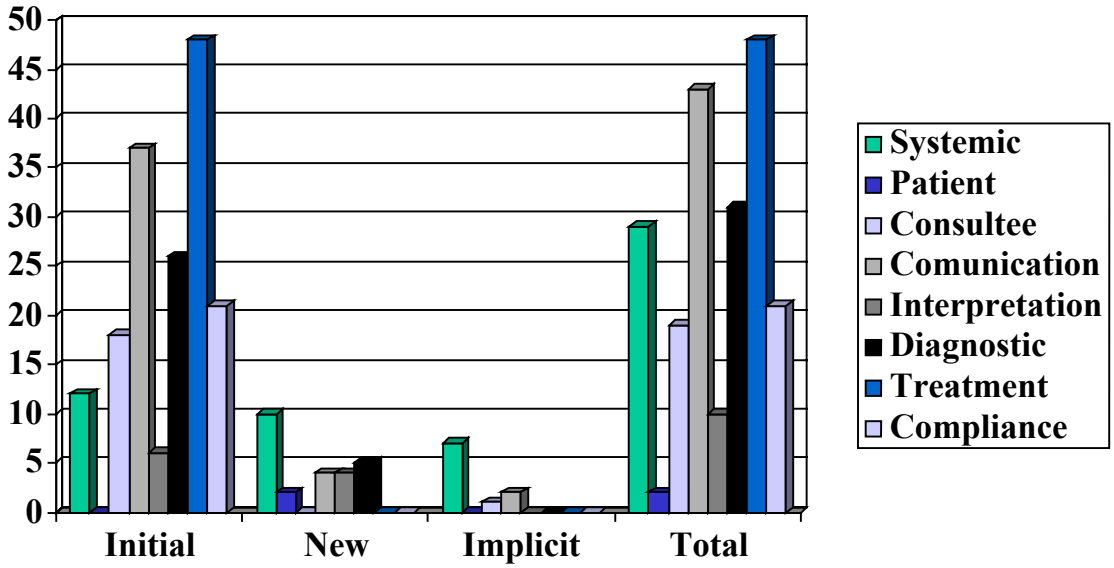
METHODOLOGY

- Measures:
  - Participant-observation & notes during case conferences.
  - Qualitative questionnaire for 3 participant-observers same day as case conference (3 to 1 hour).
  - File for each case: information on patient, clinical problem, Cultural formulation, short and long version of clinical recommendations.
  - Taping of case conference & transcription of verbatim.
- Coding & analysis: for each answer of qualitative questionnaire themes (code) were attributed; regrouping of themes into categories; negotiation between coders by triangulation; if no consensus go back to notes, transcription of case conference or tape, comparative analysis of cases to identify typology.

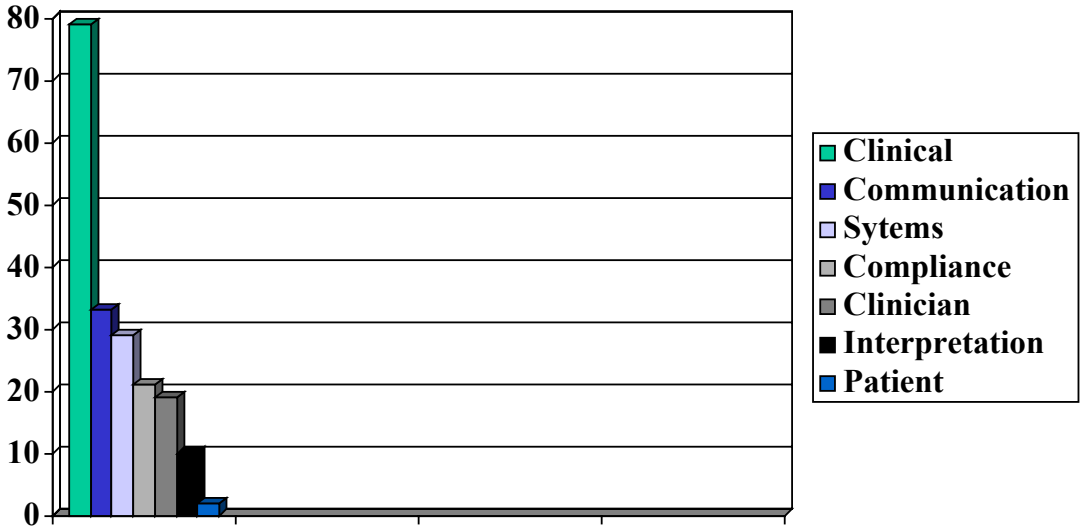
RESULTS

- Frequency of clinical problems & reasons for requesting a consultation to the CCS.
- Typology of Cultural Formulations (DSM-4).
- Procedural changes in the service that occurred weekly after each process evaluation meeting.

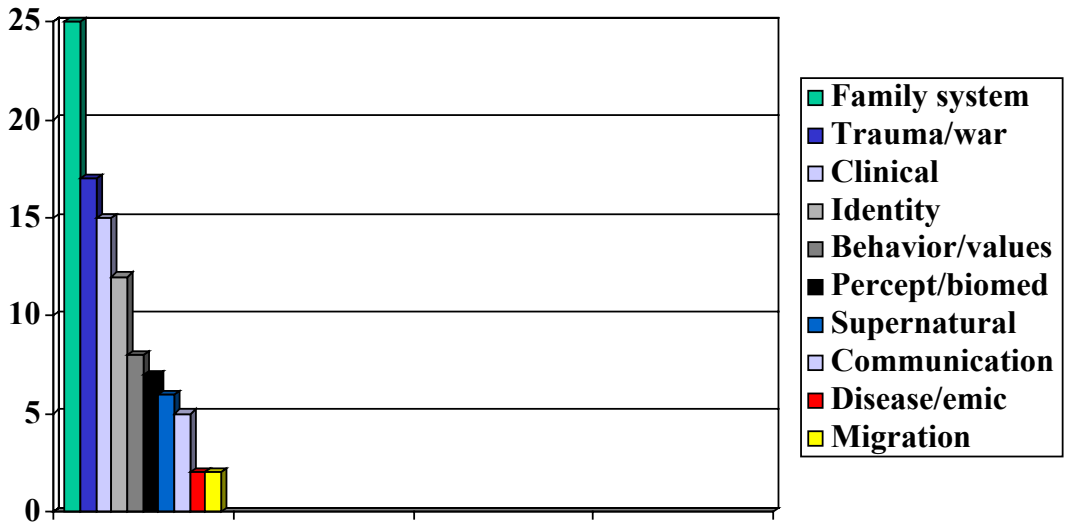
CATEGORIES OF INTERCULTURAL CLINICAL PROBLEMS



INTERCULTURAL PROBLEMS: TOTAL*



DOMINANT THEMES (3 PER CASE) OF CULTURAL FORMULATIONS*



PROCEDURAL CHANGES OF THE SERVICE

- Changes every week after process evaluation meeting.
- Prerequisites for feasibility of change:
  - democracy; power given to clinical coordinator and evaluator, time reserved to think in group (.5/week) and be creative, clear statement of participants discipline and acceptance of multidisciplinary in team.
- Procedural changes were discussed at beginning of each case conferences.
- Examples of procedural changes adopted:
  - present roles of everyone present/we finally accepted that students be present but not to say the name of patient
  - state clearly reasons for consultation,
  - we decided to ask all consultees to be present when CB does interview with patient and during case conference.
  - careful not to interrupt CB when he/she presents Cultural Formulation of case, we decide to discuss case after CB is finished (time issue)
  - should negotiate clinical recommendations with consultee and CB,
    decide to write a one page clinical recommendation the same day as case conference and give it to consultee on the spot and long version later (2 week).

PROCEDURAL CHANGES OF THE CCS

- Decide to ad certain question to evaluation protocol to refine tool:
  ex: problems and usefulness of Cultural Formulation DSM-4 ; implicit problems.
- Using a professional interpreter as a cultural broker is better than no consultation, but a tight procedure needs to be respected.
- Need to contact interpreter association to understand different interpretation models used for psychosocial cases.
- Need to contact Refugee Association to better understand current legal issues related with psychiatric evaluation.
- Procedural changes of case conferences are discussed at beginning of each case conference; we reach consensus on the importance of presenting roles of everyone present, state clearly reasons for consultation, careful not to interrupt CB when he presents Cultural Formulation, decide to discuss after CB is finished, should negotiate clinical recommendations with consultee, should write a one page clinical recommendation the same day as case conference and long version later (2 weeks).

CONCLUSION

- Consultation service and the Cultural Formulation tool addressed the issue of culture in a very systemic way:
  - Intercultural clinical competence: diagnostic etc.
  - Culture of Clinician: ethnic, social class, professional and institutional, gender
  - Culture of patient:: ethnic, social class, gender
  - Impact of the intercultural encounter between clinician & patient
  - Political and institutional contexts that might undermine not only patients but also professionals

    *** patients**: persecution, racism, discontinuity of services; complexity of systems (government, immigration, health etc).

    *** clinicians & interpreters:** need to be informed, guided and held by their peers in front of the complexity of clinical and cultural problems they have to face during many clinical encounters.
  - Limits= local study; we need comparative studies in other countries;
    - to assess the influence others contexts (immigration policy, country ideology, institutional issues of mental health system, approach used by clinicians etc)

AFFECTIVE DISORDERS IN THE STRUCTURE AND DYNAMIC OF MENTAL DISTURBANCES WITH BRIEF DURATION IN SIBERIAN TURKS

CAESAR KOROLENKO, KHUSAIN MUHOMEDZIANOV

Novosibirsk Medical Academy, Department of Psychiatry
630099 Novosibirsk, P.O.B. 29, Russia
E-mail: Korolenko@online.nsk.su

ABSTRACT

Some forms of culture-bound mental disturbances in Siberian Turks are described. The contents of the observed experiences reflect mythological beliefs which included the loss of the part of the Soul, possession by the Spirits, the loss of the connection with totem animal. The clinical symptoms of terror, fear, anxiety, delusions, hallucinations and catatonic traits were registered. Without taking in account the cultural context of disturbances the real danger of the misdiagnosis of schizophrenia existed. As a matter of fact the culture-bound experiences are often overlooked because psychiatrists as yet do not have necessary information in the field of transcultural psychiatry. Wrong diagnosis lead to the stigmatization of patients, stimulates them to learn pathological ways of relating to people and coping with life. One of the negative consequences is also one-sided orientation on psychopharmacological treatment and the exclude of the traditional shaman healing which can be effective allowing the patients to control their psychotic behavior and return to the normal life.

Brief psychotiñ disorder according to DSM-IV is the disturbance that lasts at least one day but less than one month. After the end of the disorder a patient has a full return to the premorbid level of functioning. The symptoms of brief psychotic disorder are the disturbances of the psychotic level. They can be presented in the form of hallucination, delusion. Disorganized behavior, emotional turmoil with rapid shifts from one type of emotional state to the other one. Psychotic level of

disturbance can result in the misdiagnosis of the endogenous psychosis, especially schizophrenia. Unfortunately, this situation often occurs in the cases of patients from other culture, who have difficulty in the verbal communication with doctors and psychologists because unsatisfactory knowledge of Russian language. Moreover, the patients from the various ethnic groups usually are trying to hide the contents of their experiences which is connected with general distrust to the professionals who do not have information of ethnic culture, rituals, mythology, and utilize in their work only biomedical paradigm.So, for example, culture-specific delusions can easily be regarded as attributed to the category of “bizarre”ideas typical for schizophrenia.

Brief psychotic disorders were observed in the population of Siberian Turks. Some of registered cases lasted very short-less than one day, only several minutes, and so in this criteria were beyond the time limits of DSM-IV diagnostic. These cases included patients whose pathological symptoms were explained as the influence of evil Spirits and/or the loss of the part of the Soul.

The disturbance explained as the loss of the “shadow-appearance” was single out. Siberian Turks believe that the soul of the man has its own appearance which throws its shadow out. This shadow exists as an independent Spirit which realizes the following functions:

1. acts as a guide during the travel into other worlds;
2. provides the communication with other Spirits;
3. carries out the intuitive understanding, reflects spirituality in the man;
4. forms the primary ethnic consciousness.

When the shadow-appearance come into the conflict with other Spirit the man can fall sick. The shadow-appearance continued to exist after the death of man and sometimes visits her/his relatives showing up its presence by some special signs as howling of a dog, knocking in the window, breadth of the wind.

The shadow-appearance is unchangeable. Its existence does not depend from the shifts of the man’s behavior. Nevertheless, it is extremely dangerous to photograph the shadow, throw on it some objects, especially knife or ax, shirring on it the old clothes. Such actions can induce somatic illness, or mental suffering.

The shadow disappears at night. In this period when the shadow is absent many illnesses become aggravated. Siberian Turks like to work at night when the

control of shadow is less expressed and mechanical activities are performed more easily. They prefer also work in the period of the moonlight since the shining of the moon frightens the malicious Spirits The intensity and saturation of the shadow depends on the peculiarities of the sunlight, and shifts of the mood during wethear's change are explained in the frame is the shadow strong or weak.

Brief psychotic disorder connected the loss of shadow-appearance are called "hudai turatte senerem"—"the deity has scattered the shadow".

It is short-term but severe mental disturbance. Episode lasts usually several minutes or even seconds. The state of terror is typical. The content of experiences is impossible to express by words. The patient become motionless, silent and stiff. Her/his look is rapidly changing reflecting probably the shifting contents of the experiences. Eyelashes tremble, pupils are dilated or narrowed. Patient turns blue, and this blueness radiated as though from inside. The features are pointed and sick person resembles a dead one. The patient can not to recount the happening. The impossibility to tell about this pathological event is linked not with the amnestic disorder but with the very fact that the survived experience is beyond the verbal description.

Brief psychotic disorder with delusions is called "buinam katu'-"spiritual streams emanated from the frozen mind".

The disorder develops usually after the winter and is explained as the result that the shadow-appearance became obscure. Clinical symptoms involve a feeling that the perception of the surrounding environment has changed.: all is perceived dimly, as in a twilight . The patients feel that their vital energy is decreasing and the idea that they are sinking in the "underworlds" appears. The state reveals clinic typical for oneroid-like syndrome: the patients see their dead relatives who communicate mentally with them They hear never before experienced unusual sounds . The concentration of attention on the external events is disrupted The people and their actions look strange, have for the patient some very special significant meaning. The feeling of being under the command of some alien force interpreted in the term of the influence of Spirits seizes the patients. The disturbance lasts 3-7 days. After the return to the health persons declare that they have acquired the sensation of the "empty head". The expression means that all premorbid negative thoughts and troubles have disappeared and do not torment

them anymore. Phenomenon is associated with the feeling of the gain of “new wisdom” and “mental power”. The mood in this condition is defined as “high”(euthymia). The patients are elated during few days.

In connection with the observation of this elated state it should be emphasizes that the brief manic-like states as yet did not attract special attention of psychiatrists who regard them predominantly as the mood’s shifts typical for the patients with borderline personality disorder. Nevertheless, the elated mood can be a precursor of the development of mental disorder of psychotic level and long duration We have observed a group of patients with short period of manic state (less than 7 days). Manic period was saturated by the feeling of omnipotence, sense of inner freedom, liberation from the necessity to perform artificial social roles. This state gave place to the anxiety , self-disintegration and delusions.

Brief psychotic disorder connected with the loss of the link with totem animal is called “boore boolgan”-transformation in the wolf. The ill person resembles some animal and commits antisocial actions. The person acquires often the resemblance to the wolf and people who are seeing him say: “he has transformed in the wolf”. The state lasts approximately one hour, develops suddenly, unexpectedly for the others and for the ill person himself. The symptoms include rage, psychomotor excitement and extremely aggressive behavior. Patient attacks people and objects around him, rolls on the earth, bites and eats the grass. After the end of the episode the person does not remember all details of his destructive behavior. He has a feeling that he did something bad and that his actions were beyond his own wishes and happened under the influence of alien force. Such state develops usually after the man has said aloud the name of his totem animal. Offended totem animal abandons him and he becomes the helpless victim of the evil Spirits.

Brief psychotic disorder connected according to mythology with the possession of women by the Spirit of the Red Bull is called “kizil kutalak” The sexual excitement of women is linked with the moving in their bodies the Spirit of Fertility who lives in the bulls of red or brown color. When these bulls copulate with the cows the Spirit of Fertility can move into the body of the young girl or woman if they happen to be nearby and observe this event. Possessed by the Spirit women are seized by the “Red Sexual Heat”. The three grades of

excitement can be singled out: mild, middle and severe.

The mild grade of excitement is connected with the moving in the Spirit of the young bull. The possessed woman suddenly becomes anxious, begins to pull her clothes, runs to the windows, looks out to the street. Her eyes become red, her look acquires a sexual expression. A woman in this condition can not control her conduct or speech. Nevertheless,. she tries to minimize her activity, and reveals the signs of embarrassment and shame immediately after the end of the fit. The duration of this disorder is between 20 minutes and 3 hours.

The middle stage of sexual excitement is caused by the possession by the Spirit of the bull aged under 3 years. During the fit the woman can jump out on the street. She cries out obscenities and provokes sexually men who pass by. She laughs, behaves in affected manner, touches her sexual organs, adopts sexually provocative poses. The duration of this disorder is relatively short, 5-10 minutes. After the end of the episode the woman experiences a feeling of guilt and shame.

The severe grade of sexual excitement is caused by the moving in the Spirit of the mighty red bull, older than 3 years. (The strength of the Spirit is always connected with the age of the bull). The woman is in a state of intense sexual excitement. She tears her clothes, runs along the streets, bares her legs, offends the people around her, accuses her husband of impotency, attacks and beats the wives of any men. The relatives try to catch and bind her. They pour cold water over her. These fits occur rarely, usually no often than once a year. Between the fits these women lead a regular, even ascetic life. They are modest, diligent, concentrate on their household chores. Their relatives are making an effort to give them out in marriage as soon as possible. Marriage does not save them from the attacks, but they appear less often than before and are less intensive and imperceptible outside of their family.

Among women brief state resembling alcohol intoxication was observed. This episode is called “azhdaha”-dragon.. Before its development the women noted that they have heard the sound of the humming of a bumblebee. Unexpectedly to themselves and the surrounding them people they “get drunk” without taking alcohol.. Sometimes the phenomenon is explained by the presence of alcohol at home or by the use of alcohol by others, even if these people are on a long distance from disturbed person. Nevertheless, many people think that such

women are possessed by the “wandering evil Spirits” who like as the human to drink alcohol. These Spirits are called “demons”, or “azhdaha”-dragon who can play the role of the drunk with the goal to mock at the poor unhappy woman. The hiccup that happens during the episode is explained by the fact that “the dragon yawns”.

In conclusion it must be emphasized that modern psychiatry is a product of Western culture. Through the mass media the patients have a rather stereotyped image of the psychiatrist. In condition of Russia this image is still under a negative impact of strongly ideological and biomedical psychiatry of previous USSR [1]. In the cases of culture-bound disorders patients and their relatives are especially careful and anxious to tell the psychiatrist about the cultural beliefs and rituals. In this context a meaningful dialogue between patient and psychiatrist is practically impossible. This situation creates a high risk of misdiagnosis and determines a failure of psychotherapy since cultural meaning of symptoms is not taken in consideration . The disease is primarily seen by psychiatrist as phenomenon of nature, devoid of moral implications and by non-Western client frequently as phenomenon of the supernatural, full of mental implications [2], [3]. The culture- bound systems acting in patients lead to the different point of view and outlook on a sense of social communication, environment and events. In the case of mental disturbance the possibility to feel and understand these basic differences and utilize them in the contact with patient depends on the knowledge of professional in the field of transcultural psychiatry and psychology. The formation of effective mutual professional-patient relationship can be created only on the base of the taking in account of ethnic mythology, rituals , essential motivations and the social behavior of patient. In condition of multinational society the information of the peculiarities of culture-bound mental disturbances must become a substantial part of the professional education in the clinical psychiatry.

References.

[1] C. Korolenko, D. Kensin, “ Reflections on the past and present state of Russian psychiatry” Anthropology and Medicine, 9, 1, pp.51-64.
[2] L. Jilek-Aall, “The western psychiatrist and his non-Western clientele”, Canadian Psychiatric Association Journal, 21,6, pp.353-359.
[3] W.Jilek “Traditional non-Western folk healing as relevant to psychiatry”, New Oxford University Press, 2000Oxford Textbook of Psychiatry, pp. 1509-1513.

DIFFERENCES BETWEEN ALBANIAN AND GREEK WOMEN THAT DEVELOPED POST PARTUM DEPRESSION DURING THE FIRST THREE MONTHS OF PUERPARTUM

F.Gonidakis,
A.Rabavilas,
G.Kreatsas,
G.N.Christodoulou

Athens University,
Medical School,
Psychiatric and B' Obstetric Department

Eginition Hospital Psychiatric Clinic
Vas. Sofias 74 av 115 28
Athens
Greece
Tel: 00306977370056
Email : fragoni@yahoo.com

INTRODUCTION

The image of a smiling mother who tenderly takes care of her newborn child is a well-known and widespread stereotype. We have witnessed it as children, as parents, in movies or novels. For some women though, reality is completely different. Bad mood, lack of interest for the child, despair, fear, isolation are some of they words that these women would use to describe puerpartum.

Around 10% of the women that give birth to a healthy child will develop depression during the first 3 months after delivery. Even in developed countries only a small percentage of these women will ever ask for psychiatric help. In some countries these feelings are not even regarded as a problem.

During the last ten years a large number of immigrants from Albania have settled in Greece seeking a safer financial and political environment. Many of these Albanian women decide, mainly for financial reasons, to deliver their babies at a state Obstetric clinic. There are now many second generation Albanians that have been born and raised in Greece. The Albanian family and culture shares a lot of common features with the Greek family and culture. The Albanian women that have been staying in Greece for more than ten years especially the ones that have completed their studies in Greece are usually undistinguishable from their Greek peers.

AIM

The aim of our study was to compare demographic and clinical data of Greek and Albanian women in the puerpartum and especially between them that who developed post partum depression during the first three months of puerpartum.

METHOD

405 women that delivered at the B' Obstetric Department of Athens University Medical School were included in our study. The women were followed up during the first three days of their stay in the clinic and also (after consent) with telephone calls after 1 week, 1 month, 3 months and six months of the delivery. From the 405 women 77 were from Albania, 280 from Greece and 48 from other countries.

The Greek edition of EPDS (Edinburgh Post Natal Depression Scale) and the Montgomery-Asberg Depression Scale were used for the diagnosis of Post Partum Depression.

We also used

a) A questionnaire consisting of four parts:
    1. Demographic data: age, years of education, profession, years in Greece, number and years of marriage, husband's age, years of education and profession, number of birth in the parental family
    2. 2. Medical data: family history of mental disorder, personnel history of somatic (especially gynaecological) problems and mental disorders, number of stillbirths, number of abortions, number of previous births, complications during pregnancy and delivery, weeks of pregnancy and weight of the infant, medical problems of the infant fertility difficulties, alcohol and tobacco consumption
    3. Social data: satisfaction from marriage, support during puerpartum, presence of a person who will offer advice on raising the child, presence of friends that have children of their own
    4. mother and father attitudes towards pregnancy and parenthood
b) The diagnostic criteria of DSM-IV for PMS
c) A brief Scale of 12 stressful life events
d) Symptom Check List –90 (SCL-90)
e) State Trait Anxiety Inventory (STAI 1&2)
f) Schalling Sifnaios Alexithimia Scale
g) Whitley Index (for the measurement of hypohondria)
h) Blues Questionnaire (by Kennerley)

RESULTS

Comparison between Albanian and Greek women (using chi square and t-test for independent samples)

a) Demographic Data (Table 1): Greek women were older, had more years of education and they were older children in their parental families
b) Medical data (Table 2): Greek women smoked more cigarettes every day, they reported more often that there was a family member that had or was suffering from a chronic health problem and they had more abortion that Albanian women
c) Social Data and attitudes towards pregnancy and parenthood (table3)

Greek women reported more often that they had negative feelings when they learned that they were pregnant and that they were going to have help during the first months of puerpartum while Albanian women reported more often that they were going to breastfeed their infant

d) Clinical Measurements (Table 4)

Greek scored higher than Albanian women in the SCL-90 hostility subscale, STAI-2 (trait anxiety) subscale, Schalling-Sifnaios Alexithymia Scale, the Montgomery Asberg Depression Scale that was filled in the first day after delivery and at the Blues Questionnaire that was filled in the seventh day after delivery.

Comparison between Albanian and Greek women that developed depression (table 5) (using chi square and t-test for independent samples)

There was no difference found between the ratio of the women in each group that developed depression (Greek women:18,3% Albanian women: 18,4%). The only differences that persisted in the depressed two ethnic groups concerned the tobacco consumption and the Schalling Sifneos Alexithimia Scale. Also the Greek women that developed depression scored higher than the Albanian ones in the Blues Questionnaire that was filled in the first day after delivery. (table 5)

DISCUSSION

Although the two groups of women had differences in the demographic and clinical measurements the two groups of depressed women seemed to be more similar to one another. The only differences that did not existed was the more severe symptomatology of maternity blues during the first day. Further investigation on the differences among depressed and not depressed women is needed

TABLES

Table 1 Demographic data

	Age*** Mean score	Education* Mean score	Parental family** Mean score
Greek	30,2	12,6	2
Albanian	26,1	11,8	2,5

* $p<0.05$ ** $p<0.01$ *** $p<0.001$

Table 2 Medical Data

	Cigarettes/day Mean score***	Family member with Health problem (%)*	Number of Abortions Mean score**
Greek	7,3	20,6%	0,4
Albanian	1,0	7,8%	0,1

* p<0.05 ** p<0.01 *** p<0.001

Table 3 Social Data and attitudes towards pregnancy and parenthood

	Negative feelings**	Support*	Breastfeeding**
Greek	28%	63,7%	86,1%
Albanian	14,3%	51,9%	97,1%

* p<0.05 ** p<0.01

Table 4 Clinical Measurements (mean scores)

	SCL-90** hostility	STAI 2*	S-Sifnaios*	M-A * (1^{st} day)	Blues Questionnaire** 7^{th} day
Greek	3,4	34,0	5,5	7,9	4,1
Albanian	2,0	31,3	4,8	6,2	2,6

* p<0.05 ** p<0.01

Table 5 (mean scores)

	Cigarettes/day*	S-Sifneos*	Blues Questionnaire 1st day*
Greek	8,9	6,1	4
Albanian	0	4	2,4

* $p<0.05$

AN OVERVIEW OF CULTURAL ISSUES IN PTSD
IN SYMPOSIUM:
"THE EFFECTS OF THE IRAQ WAR ON PSYCHIATRIC PATIENTS AND THEIR PSYCHIATRISTS"

James K. Boehnlein, MD

Professor of Psychiatry
Oregon Health and Science University
Associate Director for Education
Veterans Administration Northwest Network Mental Illness Research, Education and Clinical Center (MIRECC)

P3MIRECC
3710 SW Veterans Hospital Drive
Portland, OR 97239
boehnlei@ohsu.edu

ABSTRACT

The direct effects of wars, “ethnic cleansing,” and ethnic conflicts often leave their victims with multiple psychiatric symptoms. These individuals remain vulnerable to reactivation of their symptoms as a result of media exposure to other wars and other acts of violence. This presentation offers an overview of aspects of reactivation of symptoms among previously traumatized patients, and reviews cultural variables that influence PTSD assessment and treatment.

> There are such things as natural or social crises of such an order that they test all those who live through them. They are moments of truth in which, not everything, but a great deal is revealed about individuals, classes, institutions, leaders. The world at large does not usually appreciate or understand these revelations: but for all those who belong to the society or country in question, their importance and meaning are quite clear [1].

1. INTRODUCTION

The place of culture in psychiatry and trauma studies has become increasingly important in recent years. This has been largely due to increasing multi-culturalism in countries around the world brought about by migration and a revolution in technology and communication. Changes in psychiatric assessment and treatment are also related to a call from many groups for greater recognition and respect for ethnic and cultural differences. Challenges in meeting clinical needs, particularly for survivors of war-related trauma in various parts of the world, also greatly affect the direction of educational and research initiatives in cultural psychiatry.

Cultural psychiatry faces the great challenge of incorporating a rich heritage drawn from the social sciences, psychiatry and medicine into a comprehensive vision of the future to meet the mental health needs of a variety of socio-cultural traditions. And, while maintaining a systems perspective in all its pursuits, cultural psychiatry should not lose sight of the uniqueness of each individual who has suffered war trauma and the human goals of its contributions to patient care, training, and research.

In this paper, I will briefly review the theoretical base of psychiatry and medical anthropology relevant to a comprehensive view of this topic. I will then consider recommendations for positively impacting research, education, and clinical interventions internationally in trauma studies.

2. CULTURAL THEORY, TRAUMA AND HEALING

The interface of cultural psychiatry and trauma research has benefited from a rich intellectual tradition. Various research directions within the field have been influenced by anthropology, sociology, and the various schools of psychiatry. The early years of cultural psychiatry research in the first half of the 20th century were dominated by psychoanalytic anthropology, and most research was carried out by Western researchers working in developing countries with native peoples. This early work contributed much to the field and to general psychiatry by providing cross-cultural perspectives on child development, personality, family and social networks, religion, and political processes, all of which are relevant to trauma studies. Since World War II, because of historical trends, world events, and scientific advances, the field has widened considerably to include studies of migration and resettlement, acculturation, and biological factors in the cross-cultural prevalence of illness and disease related to severe trauma.

Medical anthropology has explored the social nature of the healing process, the specific roles of the healer and patient, and the interpersonal dynamics of that social interaction. All healers, regardless of their culture or ethnic group, deal with the central and ultimate issues of human existence, such as sickness, health, life and death. Although physical and psychological distress is experienced individually, it often arises from, and is worked out or resolved, in a

social context. Disease and sickness destabilize the rhythm of life [2] and often isolate the individual from the rest of the community. Part of the role of the healer, in a social context, is to reestablish an equilibrium between the person and his/her environment, whether that environment is primarily the natural world, interpersonal relationships, or even an individual's struggle with culturally specific central values. In all cultures, the healing process occurs through a system of symbols and rituals that are grounded in the traditional belief systems of the culture and performed by an individual whose role as healer is sanctioned by that society. As Fabrega [3] has pointed out, the study of forms of illness presentation and subsequent healing processes within a specific culture may allow access to the core religious beliefs, sacred values and views of interpersonal relationships which are made more visible during times of stress.

In a different realm, the explosion in biological psychiatry research in the last two decades also has had major implications for cross-cultural trauma studies. The mutual benefits that could ensue from greater collaboration between biological and cultural perspectives have been largely untapped. A major frontier is the degree to which basic neurophysiological processes may vary among different ethnic groups. Certainly, there have been major advances in the importance of ethnic factors in psychopharmacology, particularly in identifying differences in how drugs are metabolized as a function of ethnicity. But if the significance of traumatic events is to be understood in biological terms, it must be a biology that encompasses not only the nervous system but also relationships, commitments, social position, and wider systems of cultural meaning and values [4].

Additionally, an important area of study in cultural psychiatry in the past several decades has been the observation of the social effects of worldwide migrations of refugee populations fleeing war and persecution. The effects of pre migration and migration trauma have been well described, along with the challenges of post migration adjustment and acculturation. The effects of migration on subsequent generations have been described in studies of World War II refugees, but the results of research on other second-generation refugees have only begun to appear. Future family and second generation studies of long-term social adjustment among culturally diverse refugee groups may shed light on both protective and risk factors in the development of psychiatric disorders, including disorders related to trauma. The examination of the modification of social norms and cultural traditions over time within groups that have migrated is another area of fruitful study. Effects of these modifications on mental health in general, and specific disorders in particular, have implications for trauma studies. Included in this research area are studies of indigenous healing procedures and their modification in resettlement countries.

The challenges of measuring psychiatric disorders across cultural groups are quite formidable because of language barriers, variations in cognitive and emotional schemata related to social traditions and cultural beliefs, controlling for multiple social and cultural variables, and continued change in the variables studied. This is shown in our recent study of the clinical effects of the terrorist attacks of September 11, 2001 on five different ethnic groups in the Intercultural Psychiatric Program at Oregon Health and Science University [5].

Children growing up in war-torn countries face both short term effects, such as orphan status and psychiatric disorders, and long term effects, such as difficulty in moral development and poor school performance [6]. Some children become pupils of war with continued antisocial behavior and aggressive feelings that perpetuate the cycle of violence. The effects of violence are pervasive and include not only trauma but also the disintegration of families and communities, destruction of economic infrastructures, and the imposition of a general culture of fear into daily life [7,8]. Successive threats along a continuum of stress faced by refugees and other survivors of human rights violations can compound each other to challenge multiple

adaptive systems at both the individual and communal levels [9].

Difficulties that many traumatized individuals have experienced include a broad spectrum of symptoms and behavioral dysfunction, such as nightmares, intrusive thoughts of the trauma, insomnia, startle reactions, intense grief, and difficulty with concentration. These symptoms have been observed to occur in individuals and groups from a wide variety of ethnic backgrounds, with many differences in central cultural values, family and societal structures, forms of healing, and traditional religious systems.

There are certain culturally determined ways in which the symptoms and behavioral dysfunction of trauma present to health care professionals. As noted, much of the psychological distress observed universally after trauma can be viewed as being closely related to a disruption of the central values and beliefs of the particular culture. This is most frequently observed in the existential concerns patients bring to the traditional and Western healers they consult, persisting long after many of the physiological symptoms observed cross-culturally (nightmares, insomnia, startle reactions) have been brought under control with medication. It is conceivable that many of the posttraumatic symptoms observed in all ethnic groups represent a universal human response to the cognitive disruption of a sense or order and meaning that comes from a stable system of culturally specific central values.

The adjustment of Cambodian refugees around the globe over the past 20 years provides an important example of this latter point. During the years 1975-79, the citizens of Cambodia saw a destruction of life on a scale unparalleled since the concentration camps of World War II. Over those four years, at least one third of the population died of execution, disease and starvation as a direct result of policies conceived and carried out by their own government. Those individuals with ties to the traditions of Cambodian society, including political, educational, commercial and religious institutions, were specifically singled out by the government for execution. We have recently completed a study of the long-term outcome of PTSD among these patients treated in our clinic for ten or more years.

3. PRACTICAL ISSUES FOR TREATMENT AND PROFESSIONAL TRAINING

Creative health care providers across the globe will need to be trained to recognize victims of violence and potential perpetrators of violence and learn approaches to treatment that incorporate these important concepts drawn from anthropology and sociology. The following are a number of suggestions to address that need [10]:

1. Recognize the need. Develop an awareness of violence in the local culture and society, whether it is domestic violence, ethnic strife, child abuse or perhaps government sponsored actions. Consider practical issues, such as how the victims or even the perpetrators come to medical attention, and where intervention can take place.
2. Consider the needs of primary care medical providers. These medical personnel will be the first line of interaction with many victims of violence and are also locked into busy schedules. Therefore, there will need to be often rapid and efficient ways of assessing situations and concise methods for obtaining the pertinent clinical history.
3. Focus on diagnosis. Many agencies and techniques have been developed for interventions and treatments; however, the first activity of clinicians is make a diagnosis whether it is current abuse, posttraumatic stress disorder among victims, or personality disorders among perpetrators. Rational treatment follows diagnosis. Clinicians need to recognize severe psychopathology, such as PTSD, depression, schizophrenia, addiction, or antisocial behavior, and how it impacts on the issue of violence.
4. Stress the counter transference reaction. Strong feelings come forward when violence is

discussed, especially when victims are presented in a personal and sympathetic manner. Reactions include a need to overprotect, or fantasies of revenge. Likewise, angry, provocative, and aggressive patients can present challenges to clinicians for maintaining boundaries, while at the same time providing appropriate care. There is a need for faculty to honestly discuss possible responses but to maintain a model of calm, appropriate clinical behavior.

5. In past trauma training and treatment, less attention has been given to the impact of trauma on other adaptive systems, such as the ability to form and nurture interpersonal bonds, to retain a sense of identity and role function, to maintain faith in a system of justice, and to sustain a sense of existential meaning, coherence and hope [9].

4. CONCLUSION

As I described in this paper, both the process of acculturation, and more rapidly and intensely, the experience of severe trauma, may contribute to a culture's questioning its traditional values, social structure and proper place in the world. This serious questioning may also affect how individuals and groups view traditional institutions in their culture (healing systems, both secular and religious) that enable the society to process stressful experiences. This questioning may also affect the viability of the traditional symbolic systems that are used in healing. Also, productive and vital cross-cultural research has the potential for influencing public and governmental policy on a broader plane. This also has implications for focusing more attention on human rights worldwide that are suppressed by genocide, war, torture, or other types of government sanctioned violence. Furthermore, a greater understanding of cognitive and emotional processes in different cultural groups may contribute to more efficacious conflict resolution strategies in political discourse.

Successful healing in transitional cultures may require the society, individually and collectively, to restructure a view of the world that has at its core a stable and consistent system of symbols, beliefs and values to provide a sense of security and predictability. This restructuring of a stable cognitive view of a frequently unpredictable world would involve the simultaneous use of culturally specific traditional healing systems, contemporary Western health care, and possibly new approaches to treatment created through an ongoing reciprocal dialogue among healers, patients and the culture at large.

REFERENCES

[1] J Berger, *A Fortunate Man*, New York: Pantheon, 1967.

[2] HE Sigerist, "The special position of the sick," in *Culture, Disease and Healing*, D Landy, editor, New York: MacMillan, 1977.

[3] H Fabrega, *Disease and Social Behavior: An Interdisciplinary Perspective*, Cambridge: MIT Press, 1974.

[4] LJ Kirmayer, "Confusion of the senses: implications of ethnocultural variations in somatoform and dissociative disorders for PTSD," in *Ethnocultural Aspects of Posttraumatic Stress Disorder*, AJ Marsella, MJ Friedman, ET Barrity, RM Scurfield, editors, Washington, DC: American Psychological Association, 1996.

[5] JD Kinzie, JK Boehnlein, C Riley, L Sparr, "The effects of September 11 on Traumatized Refugees: Reactivation of Posttraumatic Stress Disorder," *The Journal of Nervous and Mental Disease*, vol. 190, 7, 2002, pp. 437-441.

[6] MF Macksoud, A Dyreyrow, M Roundalen, "Traumatic war experiences and their effects on children," in *International Handbook of Traumatic Stress Syndromes*, New York: Plenum Press, 1993.

[7] R Dejarlais, L Eisenberg, B Good, A Kleinman, *World Mental Health*, New York: Oxford University Press, 1995.

[8] D Summerfield, "War and mental health: a brief overview," *BMJ*, 321, 2000, pp 232-5.

[9] D Silove, "The psychosocial effects of torture, mass human rights violations and refugee trauma: toward an integrated conceptual framework," *Journal of Nervous and Mental Disease*, 187, 1999, pp 200-7.

[10] JD Kinzie, JK Boehnlein, "A behavioral sciences model in medical education: Recognition and management of violence and its effects," *Ann of Behav Sci Med Ed*, vol. 7, 2001, pp 97-101.

IMPACT OF THE IRAQI WAR ON TRAUMATIZED MIDDLE EASTERN AND BOSNIAN REFUGEES

Pamela Edwards, MD

Oregon Health Sciences University
Portland, Oregon
USA
Email: pamela.edwards@comcast.net

ABSTRACT

The psychiatric impact of the current Iraqi war was studied in 95 Bosnian and Middle Eastern refugees receiving psychiatric treatment in the Intercultural Psychiatric Program at Oregon Health Sciences University. Psychiatric symptoms, subjective reactions, whether medications were changed, and factors that aided in coping were assessed via subjective self reporting using demographic information, analog scales, open ended questions, and selecting helpful factors from a prescribed list.

Results: Ninety percent of patients saw the war on TV, causing extreme adverse mental health effects. Subjective worsening of psychiatric symptoms was marked. The Bosnian group mean for perceived safety declined 32% following the war, versus a 10% decline in the group mean for the Middle Eastern group, and Bosnians had an extreme fear that the war would come to the US. Both groups expressed anger about the war. Over one-third of the Iraqi and Afghani patients felt happy about the war. The most helpful factors for all patients were medications and avoiding TV. The least helpful factor was listening music. Middle Eastern patients found religious beliefs helpful, but most Bosnians did not.

This study shows that new traumatic events worsen PTSD and depression in traumatized patients, regardless of the amount of media exposure. Clinicians should anticipate psychiatric deterioration in traumatized refugees with new traumatic events, and specifically ask patients about their reactions. Some ethnic differences may impact the treatment.

INTRODUCTION

In March 2003, the United States initiated war against Iraq, accompanied by extensive media coverage. Nearly everyone with a television saw the war on American networks, and some Middle Eastern patients also viewed Iraqi and Kurdish television via satellite. Iraqi patients saw their homeland being destroyed, felt fear for their family members in Iraq yet helpless to assist them. Initially, Iraqi patients felt glad that Saddam's regime was destroyed, and expressed sentiments of hope for their country. As the weeks and months wore on, they became more worried about family members without food, water, or money, more critical of the United States' actions, and their mental health deteriorated. Bosnian patients were effusive and dramatic in expressing their distress, and also experienced significant deterioration in their mental health. With the marked worsening of symptoms, it was considered important to gain a greater understanding of the war's impact. This situation presented an opportunity to study several ethnic groups who are predominately Muslim, some of whom are natives of the country under attack.
The goals of the study were to:

1) describe the psychiatric symptoms that worsened due to the war
2) describe the subjective reactions to the war

3) describe the factors that aided in coping with the psychiatric effects of the war
4) determine ethnic differences in the psychiatric effects of the war

SETTING

The clinical setting for the study was the Intercultural Psychiatric Program at Oregon Health and Science University in Portland, Oregon. The program has been in existence for 25 years, and has approximately 1000 patients who speak 17 languages. Most all patients are refugees from war torn countries who have experienced significant trauma related to war and political regimes. PTSD and affective disorders are the most frequent diagnoses, with a smaller portion of patients with psychotic illnesses. Each patient has a psychiatrist, and a mental health counselor that work as a team in providing psychiatric treatment. The refugee groups in this study are as follows:

The Middle Eastern clinic began in December of 2000. The group is comprised of Afghani's, Iranians, and Iraqi's who are predominately Muslim. The Afghani patients came to the US in the late 1990's, and many are women and children whose professional husbands were killed by the Taliban. The women were not allowed to go to school, could not be seen in public without a man, and were required to wear a garment that covers the body from head to toe when in public. Many widows and children fled to Pakistan, then applied to the United Nations for refugee status and were accepted by various countries. The Iranians came to the US beginning in the 1980's due to discrimination and torture because of their B'hai faith, and many are Kurdish who were under pressure from the Taliban. The Iraqi patients came to the US after the bombings by Saddam Hussein in 1989, and many Kurdish patients living in Iraq came over the years due to ongoing pressure from Saddam Hussein. They fled frequently to Guam and Turkey, then to the US. Many of these patients are from a mid to high socioeconomic class and view their lives in their home countries as having been "very good", before war and political pressure occurred. The counselor for the clinic is from Iran.

The Bosnians came to the US following the ethnic cleansing that occurred in the former Yugoslavia in the early 1990's. They are predominately Muslim, but far less strict and observant than the Middle Eastern patients. All were exposed to war experiences including bombing, rape, and torture in their homes among other locations. Some were in concentration camps. Many escaped across the border by crossing the mountains on foot. These patients tend to be from a lower socioeconomic class than the Middle Eastern patients. The counselor from the clinic is from Bosnia, and completed medical school there.

METHODS

After the acute psychiatric needs that arose from the Iraqi war were addressed, which remains an ongoing effort, a survey was developed to assess the nature and degree of impact, and what factors aided in coping. The survey for this study was based on the survey developed by Kinzie and Boehnlein(1) for refugee psychiatric patients following the 9/11/01 attacks on the World Trade Center, and included the same questions. The survey for this study included five types of information: 1) demographic variables 2) analog scale questions about war's effect on mental health in general, depression, sleep, nightmares, flashbacks, worry about family members, fear, anger, happiness. 3) Subjective responses to open ended questions about what caused them to feel depressed, angry, fearful, happy. General feelings about the war and the most difficult aspects of the war were also investigated. 4) Chart information about whether medications were changed or

increased following the war, and 5) Patients were also asked to select all factors that aided in coping from a predetermined list.

The demographic variables included ethnic group, age, diagnosis, and years since trauma. All were asked whether they saw the war on TV, and if yes, how many hours per day of war coverage watched. Questions to which patients gave subjective answers according to an analog scale, with 0 being no effect, and 10 being the worst or most extreme effect, are as follows: 1) How has the war affected your mental health? 2) Did your sleep worsen? 3) Did you become more fearful? 4) Have you become more depressed? 5) Did you feel happy about the war? 6) Did you feel angry about the war? 7) How safe did you feel before the war? 8) How safe have you felt since the war started? 9) Have your nightmares changed? 10) At the worst, how many nightmares per week have you had since the war started? 11) Since the war started, have your flashbacks changed? 12) At the worst, how many flashbacks per week have you had since the war started? The open ended questions (all pertaining to the war) were 1) How did seeing the war on TV affect you? 2) What makes you afraid? 3) What makes you depressed? 4) What has made you feel happy? 5) What has made you feel angry? 6) Overall, describe your feelings since the war started. 7) What has been the most difficult for you since the war started? The patients' responses were quoted in writing, then categorized. Chart information included whether the patient had their psychotropic medication increased or changed since the war started. Finally, patients were asked which of the following factors helped them cope with the effects of the war: family, religious beliefs, daily routines, exercise, music, medicine, support groups, and avoidance of TV coverage of the war.

Surveys were administered by the psychiatrist and/or the counselor during regular office visits and over the telephone, because not all patients were seen in the clinic during the survey period, and we wanted to obtain data from as many patients as possible. Given the descriptive nature of the study, the patients were not randomized and there was not a control group. Ninety three percent of the 41 Middle Eastern patients were surveyed, and 60 percent of the 101 patients were surveyed. Fifteen percent of the Bosnian patients were unable to complete the survey because it was too emotionally stressful, or in a few cases they could not understand it. Patients not surveyed were either not seen during the survey period or were not reachable by telephone.

RESULTS

TABLE 1

Ethnicity	N	%Female	%PTSD	%PTSD+Depression	%Depression	%Psychosis
Afghani	21	91	5	63	24	10
Iranian	9	44	0	34	44	22
Iraqi	7	57	0	71	15	14
Bosnian	56	61	9	64	14	13
Albanian	2	50	0	100	0	0
TOTAL	95	64	6	62	19	13

Table 1 shows the numbers of each ethnic group surveyed, the percent female, and the percentage with the diagnoses of PTSD, PTSD and depression, depression, and psychotic illnesses including schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, and psychosis NOS. The average age of the patients is 46 years old (data not in table), which is

similar to the entire clinic population of 1000 patients. The gender breakdown of 64 percent female is also similar to the entire clinic population. The majority of patients suffer from PTSD and depression. This is consistent with the most common diagnosis in the clinic population of PTSD, with depression being the second most common. The percentage of patients with a psychotic illness is also similar to the entire clinic population.

Ninety one percent of the patients saw the war on TV. Of those who watched the war, the mean hours of coverage watched was 3 hours per day, with the Bosnians averaging 2 hours per day and the Iraqis averaging 5 hours per day.

TABLE 2 Mean Analog Scale Results of How War Affected Mental Health

Ethnicity	Mental Health (worse)	Sleep (worse)	Depression (worse)	Happy	Angry	Safety (before)	Safety (after)
Afghani	8.0	6.7	7.7	1.5	7.3	8.5	7.8*
Iranian	8.4	5.9	8.3	1.4	8.2*	9.6*	8.1
Iraqi	8.6	8.3*	8.1	4.8*	8.0	9.1	8.4
Bosnian	10.0*	8.3*	8.5*	0.2	5.4	8.9	6.1
Albanian	6.5	5.0	8.0	0.0	8.0	10.0	1.5
Total	9.6	7.5	8.1	0.9	6.3	8.9	6.8

TABLE 2 Continued

Ethnicity	Nightmares (increase)	Nightmares (nights per wk)	Flashbacks (days per wk)	Worry re: relatives
Afghani	7.0	4.8	6.6*	8.4
Iranian	5.3	2.5	5.7	8.4
Iraqi	8.0*	5.4*	5.0	9.3*
Bosnian	5.6	3.8	3.3	6.3
Albanian	5.0	5.5*	7.0	5.0
Total	6.1	4.0	4.4	7.6

*Denotes highest scores in category. Albanian not ranked due to N=1.

Table 2 summarizes the mean score on the analog scales for the various questions. The analog scales measure the patients subjective report of how significantly various aspects of their mental health changed as a result of the war. All patients reported their mental health worsened, by a mean of 9.6, as did sleep and depression by 7.5 and 8.1 respectively. Nightmares increased by a mean of 6.1, and at the worst occurred a mean of 4 nights per week. Iraqis had the greatest increase in nightmares. The mean number of days per week with flashbacks was 4.4. The mean for happiness about the war was less than 1, but the Iraqis did have the greatest mean for happiness at 4.8. The group mean for anger was 6.3, with the Iranians and Iraqis the angriest, and the Bosnians the least angry at 5.4. The mean increase for worry about relatives abroad was 7.6, with the Iraqis having the highest mean at 9.3. Regarding the sense of safety before and after the war, the mean for the Middle Eastern patients' sense of safety decreased by 10 percent, while the mean for the Bosnians sense of safety decreased by 32 percent.

Summary of Responses to Open-Ended Questions:

1) How did seeing the war on TV affect you?

The predominant response was simply "bad" or "very bad", especially for Bosnians, followed by having distressing memories of their own war experience evoked, especially for Bosnians,

Afghanis, and Iranians, and finally feeling "sad" especially for Bosnians. Fear, insomnia, crying, and political opinions were also noted by a few patients.

2) What makes you feel afraid?

Fear of the war coming to the United States was strikingly prominent, especially for Bosnians. Other responses included fear from seeing people killed, fear for personal and family safety, fear of bombing, and fear of the bad memories they were having.

3) What makes you depressed?

There were 4 frequent responses to this question, "killing/killing of innocents", "just thinking about the war", "bad memories", and "fear of war coming to US".

4) What has made you happy?

Among the patients that did feel happy about the war, the most common reason was seeing Saddam Hussein's regime being brought down, and belief that there now may be hope for Iraq.

5) Describe what has made you angry.

This question was the most difficult to categorize, given a wide array of responses. By far, the two most common categories of response were "killing", especially the "killing of innocents", and "why war?"/ "war"/ "war is bad", which seemed to encompass an array of strong and complex emotions. In addition, 8 percent of the patients specifically expressed anger at the United States for aggression in Iraq the sentiments being that the United States took the wrong course of action.

6) Overall, describe your feelings since the war started.

The most frequent responses were "bad", and fear/worry. Sadness was also expressed.

7) What has been the most difficult for you since the war started?

The most frequent and marked response was killing-seeing people killed and the killing of innocents. Fear of war coming to the US, and traumatic memories were also notable. Miscellaneous responses included fear of war spreading to their home country, fear for family in Iraq without food, fear of Saddam remaining in power, general uncertainty, feeling Iraq has no future, and Muslims being under scrutiny.

Psychotropic medications were changed or increased in 89% of patients, due to worsening symptoms.

TABLE 3 Factors aiding coping, % of total in category/ % within total ethnic group

Factor	Family	Religion	Routines	Exercise	Music	Medication	Group	Avoid TV
Total	53	32	48	35	26	68*	23	64*
Afghani	23/57	55/81*	30/67	18/29	44/52	22/71*	43/48	24/71*
Iranian	12/67*	16/56*	11/56*	9/33	1/22	6/44	13/33	5/33
Iraqi	11/86*	19/86*	11/71	6/29	1/29	9/86*	13/43	5/33
Bosnian	52/48	4/4	47/39	65/39	36/16	58/70*	30/12	62/70*
Albanian		3/100				1/100		1/100

Table 2 shows that the most helpful factors in coping were medication for 68% of the patients, and avoiding TV for 64%. There were not notable ethnic differences except the Middle Eastern patients were more likely to express that they could not avoid TV coverage of the war because they felt they had to know what was happening, but watching TV was quite distressing. The least helpful factors overall were religious beliefs at 32% and music at 26%, although there were ethnic differences. 90% of the patients who cited religious beliefs as helpful were from the Middle East who noted prayer and belief in God's will, whereas only 4% of the Bosnians found religious

beliefs helpful. Many Bosnian patients became tearful when asked about music. They described a loss of ability to listen to music, and only 16% of Bosnians were able to enjoy music. Twenty nine to 52% of the Middle Eastern patients were able to enjoy music. Other helpful factors in coping were family, daily routines, exercise, and support groups.

Of note, most patients appreciated the opportunity to talk specifically about their reactions to the war. The experience of the survey seemed validating for them, and they seemed to experience a sense of relief with an opportunity express themselves. It also seemed to deepen the therapeutic relationship.

DISCUSSION

Previously traumatized Middle Eastern and Bosnian refugees experienced a marked worsening of psychiatric symptoms of PTSD and depression resulting from the war in Iraq and the accompanying television coverage, which continues to serve as a repetitive traumatic stimulus.

Ethnic comparisons showed that although the Middle Eastern patients viewed more than double the amount of television coverage of the war due to a need to know what is happening in the war, Bosnians reported a greater degree of distress. Bosnians also experienced a greater decline in their subjective sense of safety with onset of the war compared to the Middle Eastern patients. The explanation for these ethnic differences is unknown, but speculations include Bosnians possibly generalizing the danger they felt as citizens of a developed and supposedly safe country before invasion and torture at the hands of the Serbians in the Bosnian war. They may feel the same could happen in the US, and that borders provide no protection. Another speculation is that Bosnians believe that when attacked, counterattack is inevitable. Therefore, when Saddam Hussein's regime (viewed as very powerful by the Bosnians) was attacked by the US, the US would automatically be counterattacked as a normal course of war. In general, the Bosnians seem much more fearful and reactive relative to the Middle Eastern patients.

Another ethnic difference is that a great majority of the Middle Eastern patients found religious beliefs helpful in coping with the war, compared to only 4% of Bosnians. The explanation is unknown, but the Middle Eastern patients are far more traditional and observant of their Muslim beliefs than the Bosnians. It is unknown whether there is any correlation between increased religious observance and less reduction in sense of safety after the war started, as seen in the Middle Eastern patients relative to the Bosnians.

In the expression of anger, Middle Eastern patients were far more likely to criticize US actions in Iraq compared to Bosnians, and had a relatively more intellectualized perspective on the war. Bosnians essentially expressed no criticism of the US. Bosnians expressed anger more as a rhetorical question, which seemed to incorporate feelings of powerlessness.

The aspect of the war that triggered the greatest anger, depression, and traumatic memories was killing, especially killing of innocents regardless of nationality. This is very problematic because the killing and its associated traumatic imagery continue on a daily basis. This creates ongoing suffering, continual symptom stimulation, and presents a major clinical challenge. At this point, 6 months after the war started, patients have not returned to baseline.

CONCLUSIONS

In this study, over 90 percent of all patients were exposed to the war via television, and reported that the war adversely affected their mental health to an extreme degree. Seeing and knowing of the killings caused the greatest distress, accompanied by fear, increase in traumatic

memories, and depression. All assessed symptoms associated with PTSD and depression significantly worsened. The Bosnian group mean for perceived safety after the war started underwent a 32% decline. The Middle Eastern group mean for perceived safety declined by 10%. Bosnians also had a great fear the war would come to the United States, which was not shared to any marked degree by the Middle Eastern patients. Nearly 90 percent of all patients had their medication changed due to their increase in symptoms. Open-ended questions revealed that the most distressing factors were killings, war in general, fear of the war coming to the US, reactivation of traumatic memories and sadness. There was some happiness about the war, especially in the Iraqis, but more patients in both groups were more likely to express anger.

Overall, the most helpful factors in coping were medications and avoidance of TV coverage of the war. Ninety percent of patients who found religious beliefs helpful were from the Middle East and 4 percent were Bosnian.

The impact of the war is ongoing, although somewhat less intense six months later. Clinicians should expect an increase in psychiatric symptoms and significant subjective distress with retraumatization in refugee patients and respond accordingly. Patients will likely appreciate being specifically asked about their emotional reactions to the traumatic event, which may provide some relief, and enhance the therapeutic relationship.

REFERENCES

1. Kinzie, J, Boehnlein, J, Riley, C, Sparr, L (2002) Effects of September 11 on Traumatized Refugees: Reactivation of Post Traumatic Stress Disorder. Journal of Nervous and Mental Disorders, 190:437-441.

ACKNOWLEDGEMENTS

Crystal Riley, M.A., Behjat Sedighi, counselor and interpreter, Amela Blekic, counselor and interpreter, J. David Kinzie, MD

THE INFLUENCE OF THE JEWISH CULTURE ON FREUD AND THE DEVELOPMENT OF PSYCHOANALYSIS

Micol Ascoli[1]
Vincenzina Iannibelli[2]
Vittorio De Luca[2]
Giancarlo Peana[3]
Ugo Lancia[3]
Maria Grazia Mazza[3]

[1]Italian Institute for Transcultural Mental Health
[2]University "La Sapienza", Rome, Italy
[3]Psychiatric Clinic "San Valentino, Rome, Italy

Italian Institute for Transcultural Mental Health
Via A. Nibby 18 - 00161
Rome, Italy
Tel./Fax. 06 – 44230467
E-mail: micol.ascoli@tin.it

ABSTRACT

Cultural Psychiatry makes us aware that psychiatric theories, including those of our Western World, do not arise in a social and cultural vacuum: they represent the result of a society's culture in a given historical period, and of the scientist's cultural values system and personality. This is true also for psychoanalysis. The psychoanalytic theory is not only a cultural and scientific product of a Western European Germanic bourgeois environment of the 19th century, as often previously reported. For a correct framing of the psychoanalytic theory, from the historical and cultural point of view, we also need to recognise and underline the deep influence that the Jewish culture had on the personality and the world view of Sigmund Freud. Nevertheless, it is surprising that the literature on this topic is astonishingly scarce and that, for several reasons, until recent times scholars have tried to affirm the universal value, more than the cultural peculiarity, of the psychoanalytic theory. While there is an amount of literature on many aspects of Freud's biography, personality and thought, it seems that his Jewish background is not fully underlined in many of those works and, until now, only a few Authors (most of who are Jewish) dealt with this issue. Freud's Jewish background and his relationship with the formulation of the psychoanalytic theory was often left aside, as if it was of a minor importance for a correct understanding and cultural framing of the psychoanalytic theory. On the contrary, the Authors believe that many aspects of Freud's theory could be more easily understood, from a cultural perspective, if we took into account their direct derivation from the Jewish culture of a given historical period. The aim of this paper is therefore to probe into some less known aspects of Freud's life and works closely related to his Jewish background: his membership in Jewish associations where he used to introduce his works before publishing them, his support to many associations for the Jewish immigration in Palestine, his close social network within the Viennese Jewish environment, his letters, his vicissitudes during the ascent of Nazism in Germany and Austria, the Jewish background of many of his first patients and students, the Jewish issues involved in his troubled relationship with C. G. Jung and the spreading of the psychoanalytic movement in Europe following Jewish "ethnic paths".

I was born on May the 6th 1856 in Freiberg (Moravia), a small town of the present Czechoslovak. My parents were Jews, and I have remained a Jew myself.[10]

This is the opening sentence of Sigmund Freud's autobiography, written in 1924. These words sound more like a proud claim of the Author's personal identity, than a serene autobiographic narration. Their ultimate meaning sounds like: "first of all, I'm a Jew, and not only because my parents were Jews, but also because I was never converted ". A few lines further down:

University, which I attended since 1873, initially gave me remarkable disappointments: first of all, I was hurt by the fact that, because I was a Jew, I was expected to feel inferior and alien to the others. I absolutely couldn't accept the idea of inferiority. I could never understand why I should have felt ashamed of my origins or, as some were already beginning to say, of my race.[10]

These words can be connected to a famous passage of *Traumdeutung [6]*, where Freud described the painful feelings he experienced during his childhood, when his father told him about a humiliation he suffered when he was young: one day, a Christian had thrown Jacob Freud's new hat in the mud, shouting "get off the side-walk, you Jew!". And all Jacob Freud could do was silently stooping to pick his hat up. On that occasion, the young Sigmund Freud found a remedy for his "dissatisfaction" by imagining Hannibal swearing revenge on the Romans.

All the above mentioned passages tell us about Sigmund Freud's early awareness of his Jewish belonging, which became for him a reason of suffering when, in a particular historical period, this belonging was stigmatized as "diversity" by the widespread hostility of an external environment that discriminated, judged and rejected those who belonged to a minority.

Nevertheless, according to Freud, it was to his Jewish nature, and to the resulting condition of diversity and discrimination, that he owed his "independence of judgement", or the personal characteristic that enabled him to build up his theory of the psychological functioning:

But these initial impressions had on me the very important consequence that I got immediately used, since the very beginning, to my destiny of staying in the lines of the opposition and to the ostracism of the "compact majority". In this way, the bases for a certain judgement independence of mine were laid.[10]

The very same concept was confirmed two years later, during the speech to the members of the Jewish association *B'nai B'rith*:

[...]only to my Jewish nature did I owe the two qualities which were absolutely necessary to me during the long and difficult path of my existence. Since I was a Jew, I found myself immune from many prejudices that limited the others in the use of their intellect and, as a Jew, I was always ready to go over to the opposition and to forgo the agreement with the "compact majority".[13]

This position of "solitary (Jewish) opposition" was even more radicalised in "The resistances to psychoanalysis", written in 1924, and originally published on the Geneva Jewish journal "La Revue Juive":

Finally, may the Author be allowed to raise, in all modesty, the question if, by chance, his being a Jew who never tried to hide his Jewish origin could have contributed to determine the

surrounding world's aversion for psychoanalysis. A topic such as this is hardly ever raised outspoken, but unfortunately I have become so suspicious that I can't shrink from the supposition that such a circumstance wasn't completely free from consequences. And maybe it was not a pure chance that the first exponent of psychoanalysis was a Jew. In order to stick to the psychoanalytic theory it was necessary to be willing to accept a destiny which nobody is so accustomed to as the Jew: it's the destiny of those who are alone in opposition. [11]

In this passage, Freud begins with a reflection on the possible influence of anti-Semitism on the world's "aversion to psychoanalysis" and then moves to another topic: is there any relationship between his Jewish origin and the formulation of the psychoanalytic theory?

In this paper, we will try to show that this is not a mere academic question. According to the Authors, Hebraism was a fundamental part of Freud's life and works and it represented an important influence on many aspects of the psychoanalytic theory and practice, and of the vicissitudes characterising the beginning of the first psychoanalytic associations in Europe. But when we tried to probe into this particular topic we realised, with much surprise, that among all the research and studies on the many aspects of Freud's thought, personality and biography, his Jewish origin was often and surprisingly left aside, and that only a few Authors (most of which are Jewish) dealt with this subject.

But what do we mean, here, by "Hebraism"? We all know that Freud was neither a believer, nor a practicing Jew. At a theoretical level, he considered the religious beliefs among the psychological phenomena susceptible of psychoanalytic investigation and he compared the religious rituals to obsessive symptoms. Therefore, here the term "Hebraism" is meant in cultural terms: a range of cultural contents in a broad sense, a compound whole of traditions, customs, world views, thoughts and relational models transmitted within the Jewish family and the Jewish community, that can't be reduced to the mere religious beliefs and precepts.

In this sense it is quite evident from Freud's works that, in spite of his firm refusal of the Jewish religious beliefs, Hebraism was a fundamental part of his world view and of his conception of the human being.

Freud's family was of Galician origin. According to Ellenberger [3], in Freud family's Bible the birth of Sigmund was registered under the Jewish name of Schlomo, on Rosch Hodesch Iyar 5616[1] of the Jewish calendar, or May the 6th 1856. Jacob Freud was a practicing Jew. The child Sigmund attended a Jewish school, where he learnt Hebrew. Since his early youth Freud established friendly relationships with a number of standing out personalities of the Austrian and German Jewish *intelligentzia*: Eduard Silberstein, Breuer and Fliess, Arthur Schnitzler, Albert Einstein and Arnold Zweig. In Freud's letters to Martha Bernays, Fliess and Zweig there are many references to the Jewish culture and to Yiddish. Those letters show that Freud had indeed a deep knowledge both of the Jewish religion and the cultural background of his origins. Cesare Musatti [29] reported that the majority of Freud's friends, intimate colleagues and first patients belonged to the Jewish Viennese community. Freud's wife, Martha Bernays, was the niece of Isaac Bernays, the Chief Rabbi of Hamburg Jewish community. After his traditional Jewish religious wedding with Martha, Freud prevented any kind of religious observance in his house. Martha was able to start observing again the Jewish precepts only after Freud's death. Nevertheless, Freud always showed to have no doubt about the Jewish identity of his family. In 1925 he wrote:

I can say I feel distant from the Jewish religion, as well as from all the other religions, in which I'm not emotionally involved even if I have the greatest scientific interest for them. On the

[1] The first day (Rosch Hodesch) of the month Iyar of the year 5616.

contrary, I always felt a strong sense of belonging to my people, and I tried to cultivate this feeling among my children. We all kept our Jewish names.[13]

His son Martin was a member of the Zionist association *Kadimah* ("Cheer up!"), that was particularly active in the organisation of the defence from the anti-Semites attacks to the University of Vienna. His brother Ernst was an architect. He was a member of the Berlinese Zionist movement and he went on a trip to Palestine, where he planned the private house of Chaim Weizmann, the first President of the State of Israel. His daughter Anna said in 1977, at the inauguration of the Sigmund Freud Center at the Hebrew University of Jerusalem:

[Psychoanalysis] was criticised for its inaccurate method, for its non-scientific discoveries, even for being a "Jewish science". No matter how we can consider those disdainful comments, I think the last one can have the value of a title of honour.[27]

Freud's membership in a number of Jewish associations is perhaps one of the less known aspects of his biography, but it's quite indicative of his participation in the lively political and cultural debate among the European Jewish communities from the end of the XIX Century to the Holocaust. In 1897, while the echoes of the *affaire Dreyfuss* were still strong, Freud became a member of the *B'nei B'rith* ("Sons of the Pact"), followed by Theodor Reik, Eduard Bibring and Otto Sperling. David Meghnagi [27] reported that *B'nei B'rith* represented for Freud a free and safe room where he could expound the results of his research, without any risk of hostile reactions: in December 1897 Freud made two speeches on dreams, and he told an enthusiastic audience about his intention to write a book on the topic; in February 1899 he made a presentation about the psychic life of the child; in February 1901, during a speech about superstition, he anticipated some of the theories published later on in "Psychopathology of everyday life". In 1904 Freud made lectures on the historical figure of Moses and on the joke; in 1913 he told his brethren about the reasons of his breaking off with Jung and he anticipated some preliminary concepts of "Introduction to narcissism" and "For the history of the psychoanalytic movement". In 1926, *B'nei B'rith* celebrated Freud's seventieth birthday. He was presented as "the mouthpiece of Hebraism" among the peoples.

Since the Twenties, as a testimony of his personal involvement in the Jewish national vicissitude in Palestine, Freud financed the Zionistic association *Hechalutz* for Jewish immigration in Palestine. Some years later his membership card and the receipt of his deposits were found by the Nazis in the headquarters of the Viennese Psychoanalytic Association. Under this pretext, the library was distrained and the Association was declared unlawful.

In this period, Freud's ongoing preoccupations for anti-Semitism in Germany and Austria are increasingly evident in his writings. In 1926, he wrote:

My language is German. My culture, my results are German. I have always considered myself as a German, until I noticed the growth of an anti-Semite prejudice in Germany and Austria. Since then, I prefer to define myself a Jew.[26]

His letters to Arnold Zweig show a deep bitterness. The Freud-Zweig correspondence during the Twenties and the Thirties can be considered as a dialogue between two Jewish intellectuals reflecting on their own identity and existence, and on the uncertainty of the future, during the precipitating political events:

About anti-Semitism I have no intention to look for any explanation. In this matter, I feel a strong desire to give myself up to my feelings and I feel confirmed in my entirely non-scientific belief that human beings are meddling and, in general, poor rabble.[19]

Circumstances, but also the recent events within the International Psychoanalytic Association, do not help my good mood. The Austrian path towards Nazism seems to be impossible to stop. Fate itself conspires with the mob. With less and less regret I wait for the curtain to fall for me.[19]

As we all know, the last years of Freud's life were embittered by the dramatic historical and political vicissitudes that led Europe to the catastrophe of World War II and the Holocaust. Freud's last works [15], [16], [17], show to be greatly influenced by the cultural and political climate of that period. "Moses and Monotheism" [15] could also be interpreted as Freud's personal research on his cultural roots, proudly reaffirmed in a tragic historical moment, and on the deep reasons for the anti-Semitic hate.

After he left Vienna for London, during the last year of his life, Sigmund Freud, seriously ill, used to follow "with great concern all the news on the events in the Holy Land" [20] and, as reported by Jones [23], he was often visited by Chaim Weizman, who, ten years later, would become the first President of the Israeli State.

The relationship between Freud and Jung was greatly affected by cultural and ethnic implications. Until Jung and Binswanger joined the psychoanalytic movement in 1907, psychoanalysis in Vienna was considered as an entirely Jewish matter. The first non-Jewish Viennese who joined the psychoanalytic group in 1908 was Rudolph Urbanitsch. Breuer, Stekel, Adler, Reik and all the members of the 1913 "Committee" except for Ernest Jones were Jews: Abraham, Rank, Eitingon, Sachs and a certain Dr. Fraenkel, who had already changed his name into Sandor Ferenczi. The Jewish presence in the Viennese psychoanalytic group was so overwhelming that Jung, after his first encounter with the group, dreamt that he was in a synagogue.

Freud proved to be aware both of the importance of this first "non-Jewish adhesion" to the psychoanalytic movement, and of the difficulties it might have originated. As a matter of fact, on 3 May 1908, Freud wrote to Abraham:

[…]Jung is a Christian and the son of a pastor, so he can find his way towards me only at the cost of strong internal resistances. This makes his alliance with us even more precious. I was nearly going to say that only his entering the scene prevented psychoanalysis from becoming a Jewish national matter.[26]

Jung represented for Freud the "Joshua" who should have lead psychoanalysis into the "promised land of psychiatry". In Freud's expectations, Jung should have ferried psychoanalysis in a non-Jewish cultural environment. Jung was a sort of "saviour son", whose appearance prevented psychoanalysis from becoming a "Jewish national matter". Unfortunately, a few years later these reveries would find their sad epilogue in the final split between Freud and Jung: a split caused by a mixture of personal conflicts, theoretical discrepancies, desires of self-affirmation, different world views and anti-Semitic influences.

After all, the preponderance of the Jewish presence in the psychoanalytic association wasn't at all an isolated Viennese phenomenon. This circumstance occurred in other European countries as well and is so well supported that we find David Meghnagi's statement [26] absolutely true, according to which the psychoanalytic movement spread all over Europe following "specific

ethnic paths". In Italy, for instance, psychoanalysis found a fertile soil in the Jewish environment: among the Italian pioneers of psychoanalysis are Edoardo Weiss and Cesare Musatti.

This phenomenon is not casual and it should stimulate us to investigate the existence of a "common matrix", shared by psychoanalysis and Hebraism. After all, the Jews have always recognised psychoanalysis as their own cultural product, as shown in these jokes:

«We have suffered so much –a Jew says to his friend -: exile, ghettos, pogroms, extermination…But see how we've got our own back!» «How?» - asks the friend - «Don't you see? With psychoanalysis!». [4]

«Why Dr Freud never laughs?». «Because laughing is forbidden by his religion». «So, he never laughs because he is a Jew?». «No, because he is a psychoanalyst».[4]

«Mr Löwy, I happened to hear that your son is studying in Vienna with Dr Freud. What will he become, after he finishes his studies?» «A misbelieving Jew.».[5]

Karl Abraham, who shared Freud's cultural universe, realised the existence of a Jewish root in Freud's works:

After all, our Talmudic thought can't have disappeared all at once. Some days ago, a short paragraph of "Der Witz" captured my attention for mysterious reasons. I looked at it with more attention and noticed that, in its opposition technique and in its structure, it was entirely Talmudic.[26]

Freud himself affirmed it clearly in the *Traumdeutung* [6], where the dreams (and the symptoms) replaced, for an assimilated Jew, the sacred texts, with the very same interpretative technique:

In the interpretation of the dream we granted the same attention to any shade of the linguistic expression of the dream itself [...]. To make a long story short, we treated as a sacred text what, according to the scholars, looks like an arbitrary improvisation, hastily bungled in a moment of embarrassment [...]. [6]

The Jewish intellect is thoughtful and reflective and tends to the analytic skill of dissecting the deep, intimate and hidden meanings of things. It's a typical Jewish idea that these hidden meanings are exactly the opposite of what appears. This particular intellectual attitude implies a continuous reversal of things into their opposite: this is true both for the study and the interpretation of the sacred texts and of the psychoanalytic theory and practice. It's quite difficult for us to imagine that a cultural product such as psychoanalysis could begin and develop in a non-Jewish cultural background. Freud's works are evidently studded with references to the ancient Greek and Roman world. This may be another reason why many other important references to the Jewish cultural background, together with real "Jewish routes" both within the most famous psychological works and some so-called "minor works", risk passing unnoticed for those who are not particularly expert in Jewish culture. Nevertheless, as reported by David Meghnagi [26], those continuous references to the ancient Greek and Roman cultures must not mislead us. This Author proposed an original interpretation of the Freudian theory of the Oedipus complex, in cultural terms. According to Meghnagi, the Oedipus was a scientific formulation of a giant cultural problem represented by the troubled and controversial relationship of a whole Jewish generation with the traditional Hebraism of the ancestors in a critical historical period, during which a

rending splitting took place: on the one side, the push towards assimilation and modernity; on the other side, the psychological need to perpetuate a cultural and religious tradition that was still desperately needed to define one's own identity.

The Authors believe that the Jewish cultural root is quite evident in many aspects of the psychoanalytic theory and practice. At a theoretical level, we could mention in particular the Freudian formulation of the Super-Ego as a psychological structure working as a critic-censor and resulting from a process of internalisation of the parental figures after the Oedipus stage. This particular definition of the Super-Ego mirrors exactly the characteristics of the parental function within the traditional Jewish family. As a matter of fact, the traditional rearing model of the Jewish child is based upon an ideal of an absolute refusal-inconceivability of the evil, with a constant concern for the moral integrity as the fundamental dimension within which the human being can realise his existence. This traditional rearing model specifically resorts to the sense of guilt - the unavoidable and undesired consequence of the fall from the heights of ethic - as a fundamental pedagogical means. The rival project of this issue is a "perverse" unconscious, inherently guilty of desires and tendencies unacceptable and unconceivable for the (moral) conscience. Therefore their only destiny is to be removed. The unconscious became, for a Jew who lived between the end of the XIX Century and the beginning of the XX, a lay room where to locate those human qualities that have always characterised the Jewish conception of the human being.

As for the psychoanalytic practice, we could mention the particular technique of the interpretation of the dream, the symptom and the slip of the tongue. This technique shares many of his aspects with the Jewish traditional methodology of the study of the sacred texts. Furthermore, the search for the origin of the neuroses in the past life of the patient mirrors the fundamental function of memory, within the traditional Jewish culture, as the basis for personal and group identity. We could also mention the therapeutic power attributed to the verbal aspects of the patient-therapist relationship in psychoanalysis: this power seems to be directly derived from the Jewish cultural value attributed to the words. Last but not least, a certain "prophetic" quality of psychoanalysis is typical of other great modern Jewish cultural products, such as communism.

In conclusion, according to the Authors many aspects of the Freudian theory become easier to contextualise and therefore understand if we take into account their direct derivation from the Jewish culture of a certain historical period. A look on psychoanalysis from a more authentically "transcultural" point of view would be, in our opinion, quite an advantageous and desirable operation, since psychological theories never arise in a vacuum: on the contrary, one of the great teachings of cultural psychiatry is that any theory of the psychic functioning is influenced both by the personality of its founder and the historical, social and cultural background in which it develops. This is evidently true also for psychoanalysis, despite the claims for its universal value.

REFERENCES

1. Arieti S. : "Il parnas" – Mondadori, Milano, 1980.
2. Einstein A. : "Pensieri di un uomo curioso" – Mondadori, Milano, 1997.
3. Ellenberger H. F. : "La scoperta dell'inconscio" – Boringhieri, Torino, 1976.
4. Folkel F. : "Storielle ebraiche" – Rizzoli, Milano, 1988.
5. Folkel F. : "Nuove storielle ebraiche" – Rizzoli, Milano, 1990.
6. Freud S. (1899) : "L'interpretazione dei sogni" – in: "Sigmund Freud. Opere", vol. III, Boringhieri, Torino, 1972.
7. Freud S. (1905) : "Il motto di spirito" - in: "Sigmund Freud. Opere", vol. V, Boringhieri, Torino, 1972.
8. Freud S. (1907) : "Azioni ossessive e pratiche religiose" - in: "Sigmund Freud. Opere", vol. V, Boringhieri, Torino, 1972.

9. Freud S. (1912 - 1913) : “Totem e tabù” - in: “Sigmund Freud. Opere“, vol. VII, Boringhieri, Torino, 1975.
10. Freud S. (1924) : “Autobiografia” – in: “Sigmund Freud. Opere”, vol. X, Boringhieri, Torino, 1978.
11. Freud S. (1924) : “Le resistenze alla psicoanalisi” – in: “Sigmund Freud. Opere“, vol. X, Boringhieri, Torino, 1978.
12. Freud S. (1925) : “Lettera al direttore del periodico ‘Jüdische Presszentrale Zürich’” – in: “Sigmund Freud. Opere“, vol. X, Boringhieri, Torino, 1978.
13. Freud S. (1926) : “Discorso ai membri della Associazione B’nai B’rith” – in: “Sigmund Freud. Opere“, vol. X, Boringhieri, Torino, 1978.
14. Freud S. (1930) : “Prefazione all’edizione ebraica di Totem e tabù” – in: “Sigmund Freud. Opere”. vol. VII, Boringhieri, Torino, 19??
15. Freud S. (1934 - 38) : “L’uomo Mosè e la religione monoteistica” - in: “Sigmund Freud. Opere“, vol. XI, Boringhieri, Torino, 1979.
16. Freud S. (1938) : “Una parola sull’antisemitismo” - in: “Sigmund Freud. Opere“, vol. XI, Boringhieri, Torino, 1979.
17. Freud S. (1938) : “Antisemitismo in Inghilterra” - in: “Sigmund Freud. Opere“, vol. XI, Boringhieri, Torino, 1979.
18. Freud S. , Pfister O. (1909 – 1939) : "Psicanalisi e fede. Lettere tra Freud e il pastore Pfister" – Boringhieri, Torino,1990.
19. Freud S., Zweig A. : "Lettere - sullo sfondo di una tragedia (1927 – 1939)", a cura di David Meghnagi - Marsilio, Venezia, 2000.
20. Freud S. : “Epistolari. Lettere alla fidanzata e ad altri corrispondenti 1873 - 1939” – Boringhieri, Torino, 1960.
21. Gay P. (1978) : “Freud, gli ebrei e gli altri tedeschi” – Laterza, Bari, 1990.
22. Gay P. (1987) : “Un ebreo senza Dio. Freud, l’ateismo e le origini della psicoanalisi” – Il Mulino, Bologna, 1989.
23. Jones E. (1953 – 1957): “Vita e opere di Sigmund Freud” – Il Saggiatore, Milano, 2000.
24. Jung C. G. (1934) : “Situazione attuale della psicoterapia” – in: “Carl Gustav Jung. Opere”, vol. X (1), Boringhieri, Torino, 1985.
25. Loewenthal E. “Un’aringa in paradiso – Enciclopedia della risata ebraica” – Baldini e Castaldi, Milano, 1997.
26. Meghnagi D. : “Il padre e la legge. Freud e l’ebraismo” – Marsilio, Venezia, 1997.
27. Meghnagi D. : “L’ebraismo di Freud” – Micromega, Gennaio 1990, pag. 160 – 170.
28. Meghnagi D. : “Jewish humour on psychoanalysis” – Int. Rev. Psycho-Anal. (1991) 18, 223-228.
29. Musatti C. : “Mia sorella gemella la psicoanalisi” – Editori Riuniti, Roma, 1982.
30. Ovadia M. : “L’ebreo che ride” – Einaudi, Torino, 1998.
31. Roazen P. (1975) : “Freud e i suoi seguaci” – Einaudi, Torino, 1998.
32. Robert M (1974) : “Da Edipo a Mosè (Freud e la coscienza ebraica” – Sansoni, Firenze, 1981.
33. Rubinstein R. L. (1968): “L’immaginazione religiosa. Studio sulla psicoanalisi e sulla teologia ebraica” – Astrolabio, Roma, 1974.
34. Schnitzler A. : “Sulla psicoanalisi”, a cura di Luigi Reitani – Mondatori, Milano, 1990.
35. Voghera G. : “Gli anni della psicoanalisi” – Studio Tesi, Venezia, 1980.

THE MYSTICAL ROOTS OF PSYCHOANALYTIC THEORY

Simon Dein

Princess Alexander Hospital, Essex, UK

The Derwent Centre
Hamstel Road
Harlow
Essex CM20 1QX
UK
Tel: 01279-827262
Fax: 01279-454018

ABSTRACT

This paper examines the similarities and differences between ideas deriving from Rabbinic and mystical Judaism and psychoanalytic concepts. It will present material both from the Talmud and the Kabbalah (particularly the Zohar and Lurianic Kabbalistic writings). While not arguing necessarily for any historical continuity it explores how Jewish ideas provide a deep structure underlying psychoanalytic thought.

Kabbalah and psychanalysis share an emphasis on restitution. For Kabbalists it is the soul which is reconstituted and for psychoanalysts the self. Both aim to explore the conscious and unconscious aspects of existence, the obvious and the esoteric. The similarities between Freud and Klein's ideas and Kabbalistic themes are discussed.

INTRODUCTION

"Why was it that none of all the pious ever discovered psychoanalysis? Why did it have to for a completely Godless Jew? "asked Freud in a letter to his friend the Reverend Oskar Pfister (Meng and Freud 1963)? Is psychoanalysis a 'Jewish science'? Did Jewish themes influence the development of psychoanalytic theory? These issues have raised much debate among both psychoanalysts and medical historians (Ostow 1982, Ellenberger, Bettelheim 1983, Bakan 1963, Berke 1996)

The relation between Judaism and psychoanalysis has been discussed by a number of authors who draw parallels between Ideas deriving from the Talmud and Jewish mystical texts and the theories of psychoanalysis. Bettelheim (1983) argues for the centrality of the soul in Freud's thinking. According to him it is erroneous or inadequate translations of Freud's writings along with the need for scientific respectability which have distorted an understanding of Freud's intentions such that the notion of the soul has become secularised in psychoanalysis. Cooper (1996) points out the relation between the Rabbinic concepts of *Yetzer Tov* (good inclination) and *Yetzer hara* (bad inclination) to the psychoanalytic idea of the ego and id. Others have discussed the similarities between the Rebbe-Hasid relationship and the psychoanalyst client relationship (Woocher 1978, Safier 1978). Although all of these topics great interest they will not be discussed further. Here we specifically examine the ways in which Freud and Klein were influenced by Jewish mystical concepts.

FREUD AND KLEIN: THEIR JEWISH ROOTS

Born in Moravia in 1856 Freud spent most of his life in Vienna. Both his parents derived from Galicia, an area which was highly influenced by Hasidism. Freud did knowledge that his father Jakob came from a Hasidic environment and he himself was familiar with mystical texts. We know that he had great interest in the work of Rabbi Chiam Vital, the renowned sixteenth Kabbalist and principle disciple of Rabbi Isaac Luria (the Ari) and had many books on Judaica and Kabbalah in his library. Although he rejected the ritualistic aspects of Judaism vigorously, possibly on account of his discomfort of Jewish marginality, for Freud his interest in Judaism lay in both a common identity and a readiness to stand up to a common enemy, in this particular case anti-Semitism. Nevertheless he still saw Judaism as especially congenial to psychoanalysis (Ostow 1997).

Melanie Klein was born in Vienna in 1882 and she is considered by many to be Freud's foremost follower. Her father came from an orthodox Jewish family and her mother was the daughter of a Rabbi. Although she herself was not observant or religious in adult life, she did have a Jewish upbringing and maintained a particular fondness for *Yon Kippur* (the day of atonement).

FREUD'S INTEREST IN MYTHOLOGY

Freud implied in his writings that although he was familiar with classical Greece and Rome, he knew almost nothing about Jewish history. This however is unlikely to have been the case. Ostow (1965) has suggested that Freud had a good knowledge of Judaism and its mythology and its history, much of which he obtained in his youth. Apart from understanding the individual psyche, he held that the psychoanalytic method could be applied to myths with the aim of elucidating the early history of a group (particularly his work *Moses and Monotheism* relating to his attempt to understand the Jewish people through the Oedipal paradigm) and encouraged his students to investigate the possibility of a psychoanalytic study of mythology. Some of his disciples such as Jung and Theodore Reike made the study of mythology central to their own studies of psychology taking classical myths as clues to a transcendent eternal psychological reality from which each individual psyche derives. Here we argue that Freud was influenced by the Kabbalistic mythical corpus and some of his psychoanalytic ideas may have derived from it.

THE KABBALISTIC MYTH .

The term *Kabbalah* (`tradition' or that which had been received) has been used since the 11th century CE to refer to a diffuse tradition of Jewish mystical thought said to be "hidden" in religious law and which was received from the remote past, perhaps even given to Adam from the angels before the fall. It is said to have first been communicated as secret teaching to a privileged few, but by the early modern period had become a more open pursuit particularly in Hasidism. The most important of the more than three thousand extant texts is the *Zohar,* edited in the late thirteenth century probably by Moses de Leon (died 1305) and which came to be regarded as the "bible of the Kabbalists" and is a lengthy collection of tales, anecdotes, homiletics, and commentaries. The ideas were further elaborated by Isaac Luria (1543-1572) in Palestine in what is known as the Lurianic Kabbalah and which introduced a strong messianic element.

The Zohar explores the inner workings of the divine in its relationship to man. Its recurrent themes are the nature of the deity and his manifestations in the universe; the mysteries of the divine names; the soul of man, its source and future destiny; the nature of good and evil; the importance of the written and oral Torah; the expected coming of the Messiah and the future redemption. It speaks of the ultimate ultrahuman order as manifest in man, one which can be directly known through study or ecstatic experience. The experienced phenomenological world can be understood as an imperfect reflection of hidden, `deeper' or higher principles. Knowledge of these can serve as a practical key to confer insight and sometimes power over mundane everyday events. The Zohar contains a number of medical and demonological themes.

According to the Zohar, the Infinite (*En Sof)* himself without qualities or attributes, made his existence perceptible by projecting ten successive channels of light, the *sefirot* in order to serve as media for his manifestations in the finite. These sefirot are understood as the names, agencies, attributes and qualities of God and are the divine attributes which make up all existence. They are the ten divine structures which bring the world into being through emanation and make up the different levels of reality. They act as intermediaries between the completely spiritual and unknowable creator and the material world.

The ten Sefirot form a unity and should not be thought of as separate entities. They are figured in different patterns but may be divided up into three triads; the first representing the imminent intellectual power of the universe; the second the moral world and the third the physical universe. The tenth sefira is the female aspect of the divinity, the *shekinah.* The human individual is understood as a microcosm of the whole universe by which each person reproduces what is above in the celestial worlds. The Sefirotic structure of man simultaneously reflects and is reflected onto that of the universe, and the Sefirot may be represented in various ways as concentric circles, as the tree of being or as the cosmic man, *Adam Kadmon* . The Sefirot are immanent in bodily experience. As the Zohar states (2.212):

"We were formed after the supernal pattern, each limb corresponding to something in the scheme of wisdom".

EXEGESIS IN PSYCHOANALYSIS AND KABBALAH

For a greater understanding of the influence of Kabbalah on psychoanalytic work we must turn to Bakan's (1965) text. *Sigmund Freud and the Jewish Mystical Tradition*, a text which is generally ignored by psychoanalysts perhaps because they do not want to be reminded that their origins lie in the spiritual (and mystical) as opposed to a scientific tradition. Although few contemporary analysts would acknowledge that any element of mysticism informs their psychoanalytic practice, this text presents a cogent argument for a major influence of Kabbalah on psychoanalytic thinking.

."…..the contributions of Freud are to be understood largely as a contemporary version of, and a contemporary contribution to, the history of Jewish mysticism. Freud consciously, or unconsciously, secularised Jewish mysticism; and psychoanalysis can intelligently be viewed as such a secularisation" (1965:25)

Judaism has always had a strong hermeneutic tradition with an emphasis on moving beyond the manifest text to excavate the hidden or latent meaning. Biblical exegesis has preoccupied Jewish thinkers, theologians and teachers for centuries before the destruction of the second Temple well

into the present. Mysticism and psychoanalysis share similar purposes. Both relate to the acquisition of esoteric knowledge. In the former case the knowledge it is the transcendent. In the latter case it is knowledge of the unconscious. In both cases this knowledge is liberating. It is a common experience of the mystic to feel he is beyond mundane physical constraints. Similarly the neurotic feels a sense of freedom and relief once he or she has worked through neurotic conflicts.

Bakan (1965) argues that Freud's methods in particular 'free association' are similar to those developed by the early Kabbalists, especially the thirteenth century Spanish Kabbalist, Rabbi Abraham Abulafia who strove to 'unseal the soul, to unite the knots which bind it' hence developing a theory of repression and a way to deal with it six centuries before Freud. Abulafia emphasised the mystical logic of letters, the logic of God's real world which for Freud became the logic of the unconscious elaborated by linguistic processes (Berke 1996:852). He described the form of free association which he called "jumping and skipping" which involves according to Scholem (1955: 135-136):

"a very remarkable method of using association as a way of mediation…..every 'jump' opens a new sphere….within this sphere, the mind may freely associate. The "jumping" unites, therefore, elements are free and guided association and is said to ensure quite extraordinary results are far as the "widening of the consciousness" of the initiate concerned. The "jumping" brings to light hidden processes of the mind".

Let us move on to consider the Torah. This involves an almost identical process. The Hebrew word *pilpul* designates an exercise in exegesis dating back to the Talmudic period and continued by *yeshivah* students thereafter. It involves an excavation of the Torah for deeper principles. We read in the Zohar (1984:211)

"thus had the Torah not clothed herself in garments of the this world, the world could not endure it. The stories of the Torah are thus only her outer garments and whoever looks upon those garments as being the Torah itself, woe to that man….observe this. The garments worn by man are the most visible part of him, the sense of people looking at the man do not seem to see more in him than the garments".

There is an interplay between *Nigleh,* the revealed Torah and *Nistar,* the hidden Torah. The Torah is the Jew's word of God. It contains but also conceals his hidden illumination. One can penetrate the outer garments to uncover hidden meanings of the word. In the interpretation of scripture the Zohar employs four methods which are known by the Hebrew word *pardes* made up of their initial letters: *peshat* (literal interpretation), *remez* (allegorical), *derush* (hermeneutic) and *sod* (mystical).

As Scholem (1954:14) states:

"The Torah is to [Jewish mystics] a living organism animated by a secret life which steams and pulsates below the crust of literal meaning; every one of the innumerable strata of the hidden region corresponds to a new and profound meaning of the Torah. The absence of numerals, vowels or punctuation in the written Torah leaves it open to a large number of interpretations and some have argued that there are actually six hundred thousand possible interpretations of the Torah, corresponding to the six hundred thousand holy souls each of whom has a letter in the Torah."

KLEIN AND CONTAINMENT

There are similarities between Kleinian thoughts about containment or holding and the Kabbalaistic idea of *shevirath ha-kelim,* the breaking of the vessels, According the great Kabbalahist, Rabbi Isaac Luria, when God created the world he drew his light into a single point, a process which is referred to as *tzimtsum.* In a vacuum left by the original contraction light continued to pour in. It was necessary to contain this in a vessel. However, the vessel shattered resulting in shards or fragments containing seeds of the original light. The fragments with the embedded light are known as *Klippot* and are responsible for the existence of evil. The whole point of existence is to free the light trapped in the vessels, undo this exile and re-establish God's unity.

What is the relationship between this process and Klein's ideas? For Klein, when a child is born, the unity between the child and his mother is broken. The child cannot contain the primary impulse which Klein recognises as a life impulse and death impulse (Freud's *Eros and Thanatos*). For Klein the child needs to contain these impulses to protect himself from terrible internal tension. To do this he splits or shatters his mind and projects large parts of himself outwards into others. The outer world becomes full of bad persecuting bits and pieces. To deal with the emptiness he may take back or introject many of the bad bits.

The Kabbalistic process of disintegration is repaired by establishing a relationship with God. In the same light for Klein the child can be a functioning container of his own impulses and life forces by re-establishing a close relationship with those who love and care for him. A strong containing function is the requisite for order. In the first few months of life Klein argues that the child realises that the mother he loves and the mother he hates are the same person. This instigates what Klein calls the depressive position, when the child becomes more concerned with preserving another rather than preserving himself and marks the onset of mental and emotional integration. Lutzky (1989) in her paper 'Reparation and Tikkun', points out that both the Kabbalah and Klein use similar processes and symbols to affect repair. In the first instance reparative energies involve unification/integration and in the second containment/internalisation.

THE MYSTICAL TRANSFERENCE

Are the processes of psychoanalysis and mysticism so very different? In all mystical traditions the aim is to obtain unity with God. Similarly there are times during the analysis where the patient yearns to unify with the parent or the parent's representative, the analyst.

"There are periods, however, in many or most analyses when the patient yearns to be close to , and intimate with, to know and to merge with the parents and the parents' representation, the analyst . Such wishes are normal childhood wishes and they are reactivated in adult mental illness , but also in transference. When an illusion of merging develops, the transference acquires a mystical quality . It creates the impression of reunion with a parental object., the precursor of the image of God." (Ostow 1982:7)

This experience has all the characteristics of a mystical experience: it is private, it is extremely gratifying, is associated with an altered perception of reality and is not easily susceptible to communication

CONCLUSION

The above writings are strongly suggestive of an influence of Jewish mystical ideas on the thinking of both Freud and Klein. We have not been able to examine the influence of mystical ideas on other analysts. Every theory however has its critics. Although Bakan suggests that the discipline of psychoanalysis is a secularisation of Jewish mysticism, this theory has been disputed by Ostow (1982) who sees little merit in this hypothesis. He argues that whatever mystical element contributed to the creation of psychoanalysis cannot be distinguished from the mysticism of many other scientists such as Newton and Einstein who sought to elucidate what they considered to be the ultimate unity of the universe.

For Ostow there is nothing to warrant the mysticism in psychoanalysis more closely with Jewish mysticism than with Christian (the *unio mystica)* or secular mysticism. The challenge remains to further examine the influences of mystical thought on the development of psychoanalysis. Such a task requires an exploration of religious influences both from within and from outside Judaism which might have influenced Freud's ideas.

REFERENCES

Bakan D 1963. *Sigmund Freud in the Jewish Mystical Tradition.* New York: Schocken Books

Berke J H. *Psychoanalysis & Kabbalah*. Psychoanalytic Review 83 (6) 849-863

Bettelheim B 1983. *Freud & Man's Sole*. London: Chatto & Windus

Cooper H. The cracked crucible: Judaism & mental health in D Bhugra *Psychiatry & Religion Context, Consensus & Controversies*

Ellenberger H 1970 *The Discovery of the Unconscious*. London Fontana

Lutsky H 1989. Reparation & Tikkun: A comparison of the Kleinin & Kabbalahistic concept: *International Review of Psychoanalysis* 16 pg 455

Meng H & Freud E I 1963. Psychoanalysis & Faith: *The Letters of Sigmund Freud & Osker Pfister*. Translated by Eric Musbacher: New York: Basic Books

Ostow M 1997 (1982). *Judaism & Psychoanalysis* London: Karnac Books

Safier J C.1978 Hasidism, faith & the therapeutic paradox. *Journal of Psychology & Judaism* 3(1) 1 – 47

Scholem G 1955. *Major trends in Jewish Mysticism.* London: Thames & Hudson

Woocher J. The Kabbalah, Hasidism & the life of unification. *Journal of Psychology & Judaism* 1978 3 No! 32-37

MIGRATION AND SCHIZOPHRENIA. AN ONGOING STUDY IN ANDORRA

Joan Obiols-Llandrich
Noemí Cerulla
Emili Bayona

Mental Health Services- S.A.A.S.- Andorra

Fiter i Rossell 1-13, Escaldes. Andorra
Tel .: + 376 871 178
Fax: +376 864 816
E-mail: jobiols@andorra.ad

ABSTRACT

The relation between migration and schizophrenia continues to be a controversial issue. After the seminal studies by Ödegaard in the 30's, much research has been done all over the world. The surprising findings of the research done in the United Kingdom in the last decades pointing to a very high proportion of schizophrenia among migrants are reviewed. Trying to shed some light on this unclear topic, a research on the frequency and evolution of first psychotic episodes is on the way in Andorra.
Andorra is a unique case among European countries as 70 % of its population is of migrant origin. The country has only 67.000 inhabitants and this small number is a problem for epidemiological studies. In the last two years we have been collecting data on first psychotic outbreaks and following the evolution. Two main groups have been formed: patients of Andorran origin and patients from migrant origin. We intend to study after 3 years the outcome of those patients. Although the number of patients is very small, so far, one of the initial findings seems to be the presence of florid psychotic episodes among migrants with a rapid resolution and not leading to a diagnose of schizophrenia.

1.INTRODUCTION

Schizoprenia is a form of severe psychotic disease that represents a high personal, social, familiar, labour and economic cost because of its chronic evolution and also by the fact that it usually begins at early stages of life.
According to the WHO, about 45 million people in the world might be affected by this disease in some time of their life. Schizophrenia is one of the top ten diseases causing more discapacity but, at the same time, there is a general lack of financial resources devoted to the care and treatment of the persons suffering from it. Despite these negative facts, it is also true that treatments encompassing a bio-psycho-social scope have been showing better effectiveness and, nowadays, up to 77 % of schizophrenic patients can be free of relapsing.
We do not know exactly the etiology of schizophrenia and big efforts are being made to unveil the causes. It is suspected that they are multiple and represent a complex interaction of biological and environmental factors.
The *International Pilot Study of Schizophrenia* (IPPS) established the life-prevalence for this disease in about 1 % all over the world through a study made in ten different countries.

Some authors have criticized the results as some of the findings were quite different according to the different centers where the research was made. It was then suggested that some diagnostic errors might be done in the sense of misdiagnosing as schizophrenia what were in fact schizophreniform psychoses [1].
Some doubt was cast on the application of western nosological categories to other cultures members. This might compromise the validity of diagnostic categories [2].

2. STUDIES OF SCHIZOPHRENIA AMONG IMMIGRANTS

The growing immigration in the United Kingdom in the 70's allowed to study the disorders of the psychotic spectrum in samples of patients of different cultural background. The new research findings were quite surprising as they showed very high figures of incidence of psychotic disorders. The rate of psychotic illness incidence was from 3 to 6 times greater among migrant population compared to natives[3]. Some authors considered the possibility of misdiagnosing to explain these findings with the hypothesis that a great amount of so diagnosed schizophrenia might in fact be acute psychotic reactions. A longitudinal control of patients should be necessary to confirm this hypothesis[4].
The replication of these incidence studies confirmed the findings with different figures, but surprisingly high in most cases for immigrants: rates 5 times higher for those coming from the West Indies, 4 times higher in African migrants, 3 times higher in immigrants from India [5], 14 times higher in young Afrocaribbean in Great Britain [4], until 30 times higher in young immigrants from West Africa aged from 25 to 35 years-old [6].
Those findings implied a revolution in the field of psychotic disorders for several reasons: among the studies samples, the theoretic world prevalence of 1 % was no longer found; the diverse incidence figures cast some doubt on the relevance of the research methods as well as the diagnostic criteria; and, especially, the study of this phenomenon might bring some information about the etiological factors implied [7]: Do immigrants have a higher susceptibility to psychotic disorders, and especially, to schizophrenia ; do all migrants show the same high rates of incidence ?; do they all show the same susceptibility ?; do social factors play a role ?; what role do these social factors play in the outbreak and the outcome of the disease ?; are there differential characteristics in immigrants and natives in the beginning and/or the evolution of the disease ?; what kind of biological factors might intervene ?; what kind of pychotic disorders are more frequent in one or other population ?; is there a relation between cultural background and higher incidence of psychotic disorder ?; what is the exact part played by migration itself ?; what is the role of transcultural adaptation ?. Most of these questions remain still without a clear answer.
Even more surprising was the finding that the rates of psychotic disorder incidence were significantly higher among second generation immigrants than among first generation immigrants [6,8,9,10,11].
Many different hypotheses have tried to give a coherent explanation to all these diverse data but none has been confirmed.

3.CHARACTERISTICS OF PSYCHOSES IN IMMIGRANTS

Besides the epidemiological data presented, many studies have shown phenomenological differences referred to symptomatology and outcome of schizophrenia comparing inmigrant and native patients.

The IPSS had already shown that the outcome of schizophrenia was better in developing countries compared to developed ones [12]. Some studies found similar results [13,14] while other researchers found the opposite [15].
Most findings come along with hypotheses trying to explain and encompass in a comprehensive way the observed phenomena but the disparity of the results make this task very difficult.
About the outbreak of psychotic disorder, most studies do not find differences comparing inmigrant or native patients [11] or among different ethnic groups ("black", "Asiatic", "white" and "others").
If we turn to the evolution and symptomatology, most studies find a better evolution of psychotic disorder among migrants. McKenzie [16], Callan [17] and later on, Harrison [18] describe a more benign evolution in immigrants in terms of a better resolution of positive symptomatology while no difference was found in the evolution of negative symptomatology.
In the same direction, the work of Brekke and co-workers [19] show that the group of ethnic minorities (Latin and Afroamerican) have a "softer" symptoms profile; non minority groups (whites, representing 51.6 % of the total sample) showed many more symptoms than ethnic minorities.
On the relapse question, although the more benign evolution of psychotic disorder among immigrants has been frequently reported, some studies [20,21] describe higher relapse rates for immigrants, especially those from Afrocaribbean origin, compared to those of white or Asiatic origin.

4. LIMITATIONS OF THE STUDIES

The reviewed studies are descriptive and from, a methodological standpoint, they have some limitations that we should not forget in interpreting the results.
To begin with, most studies have been made in Great Britain. So, more studies are needed from other countries and other cultural settings in order to evaluate the possibility that the higher rates of psychoses among migrants found in Great Britain might also be found elsewhere.
On the other side, the methodology used in these studies is diverse and this makes comparisons quite difficult. Although most of the studies point to the same direction, some of them show opposite results.
One evident limitations come from dividing immigrants in groups. Many studies try to solve the problem by considering the area of origin (for example "Asiatic") or, sometimes, by the color of the skin ("black" or "white", "Latin", etc) but, from an anthropological point of view, this not the best solutions as people from a very different ethnic background are being unfairly grouped. This might cause an important distortion in the results.
Many studies lack a strict control of socio-demographic variables such as social class and economic status. This is a limitation as these aspects might be playing a role in the appearance of a stress burden that might –according to the theory of vulnerability-stress- lead to the disorder outbreak.
Other methodological limitations of these studies include the low number of patients in some samples and possible biasing in recruiting the study subjects as most of them come from hospitals while primary care services or other institutions are not contemplated[18].
Even though the presented findings are very important, the study of more specific aspects like the cultural ones, the impact of migration, the transcultural adjustment or racism has been lacking and this represents a failure as these factors might play a role in the outbreak or course of schizophrenia [16]. The study of social and cultural factors would allow us to deepen in the knowledge and a better understanding of psychotic disorders. We should take care of the high global cost of these diseases, especially when they turn chronic; we should also find other methods of study closer to reality and

take advantage of disciplines that can bring a methodological help and knowledge in order to encompass all the aspects that might intervene in the genesis of the psychotic disorders.

5. ETIOLOGICAL HYPOTHESES: SOCIAL AND BIOLOGICAL FACTORS

Schizophrenia is a disease where it is widely accepted that genetic-biological and environmental factors interact. Studies on migrant population offer a unique opportunity to analyze the relationship between environment and clinical findings [22] and , as it was said before, studying the life-styles of minority ethnic groups can bring information on the etiological factors implied in psychotic disorders [7].

The hypotheses centered on social factors as responsible for psychotic disorders emphasize the precipitating psychosocial aspects issued from the disadvantage conditions where the immigrants find themselves [23,24,25,26,27,28]. According to these authors, the stress associated to migration would play a major role in the outburst of schizophrenia . This stress, associated to the needed resetting in the host country, would increase the vulnerability to psychiatric disorders in immigrants. However, it is hard to understand why schizophrenia rates are higher tan those of other mental disorders [29,30]. Moreover, this hypotheses cannot explain why the incidence rates are higher in second generation immigrants.

Other authors [31, 28, 23, 32] suggest that racial discrimination suffered by immigrants would induce social disadvantages that would also be factors resulting in predisposition to mental disorders.

King et al [33] think that social and personal pressures derived from belonging to a minority group in Great Britain are important determinants to explain the excess of psychotic disorders found.

Many researchers [34,35,36,37] indicate that there is no clear evidence for the hypotheses based in social disadvantages as adverse life-events do not seem to be commoner before the beginning of schizophrenia in immigrants than in control subjects. It could also be hypothesized than, more than a number of adverse life-events, it is the presence of a chronic situation of disadvantages and social unease what might be acting as a factor of vulnerability or even precipitating the disorder. Anyway, the evidence for stressful life-events or adverse circumstances as etiological factors of schizophrenia is still unclear [35,28]

The hypotheses of misdiagnosing has also been argued to try to explain the high rates of schizophrenia. Stevens and Wyatt [38] indicate that in many cases, schizophrenia is diagnosed in instead of schizophreniform psychosis. To be sure, it would be necessary to undertake a follow-up study comparing migrant and non migrant patients to determine their outcome.

Several authors [29,39,31] refer to the tendency of some clinicians to diagnose schizophrenia as well as to diagnostic changes in patients from a different cultural origin. Again, some psychotic acute reactions would be misdiagnosed as schizophrenia. It must also be stated that we need transcultural adaptations of scales and tools used in biomedicine to reach diagnoses.

There is also some evidence against these hypotheses : some maintain that the course and symptomatology of British and Afrocaribbean patients diagnosed as schizophrenic are similar and this would discard the hypotheses presented [40].

If we turn to the other side, the biological factors, we can go back to the seminal work by Ödegaard from1932 [41]. To explain the high rate of schizophrenia found among Norwegian immigrants in the U.S.A., he suggested the selection hypothesis according to which the subjects that migrate were more prone to mental disease; the presence of a latent mental illness might be a stimulus for migration.

This theory might be useful to explain the high rates of psychoses among first generation immigrants compared to natives, but it does not account for the fact that the second generation immigrants show

the highest rates of psychotic disorder from all the studied samples and this subgroup is born in the host country.

Viruses and other infectious agents are also part of biological etiology hypotheses after the observation of some phenomena that point to a relationship between psychotic disorders and viral and infectious diseases. It has repeatedly reported that there is an excess of winter-born schizophrenic patients in both hemispheres. This fact has been frequently associated to seasonal changes of infectious diseases [42]. Watson et al. [43] observed in an epidemiological study a higher rate of schizophrenia in the years when higher levels of infectious diseases were observed, especially, influenza, diphteria and pneumonia. Torrey et al. [44] described as well a positive correlation between schizophrenic births and rates of measles, chickenpox and poliomyelitis.

According to Wing [45], the underlying hypothesis to these phenomena would be that second generation immigrants would be particularly at risk to suffer intrauterine infections if they are not protected by maternal antibodies to the virus to whom the mother (first generation immigrant) would not have been exposed before. Also in this line, King and Cooper [46] think that perinatal infection might lead to an inmunological dysfunction and the disease in the adult could then be triggered by exposure to the same agent or a similar pathogen.

There is also some evidence –even though non fully consistent- that obstetric complications are associated with the further development of schizophrenia [47,48,49,50]. Schizophrenic individuals with previous obstetric complications would have less genetic load [51,52] and an earlier outbreak of the disease [53,54]. .

ANDORRA. A MIGRANTS SOCIETY

After this overview on the migration and schizophrenia relation, let's turn to a very particular case which is the Andorran society. Andorra, one of the so-called European micro-states, is a sovereign country located in the middle of the Pyrenees, between France and Spain. For centuries it has been able to remain independent and neutral in front of the surrounding conflicts. What was once a poor peasant and shepherd society hidden in the narrow valleys of the country is nowadays a wealthy land with more than 10 million visitors every year, attracted by the ski resorts and the lively commercial activity. With only 67.000 inhabitants in its 468 sq. Km, Andorra has almost 70 % of inmigrants, a unique case among European countries. From the total population, we have 32 % of Andorran people, 43 % of Spanish, 11% of Portuguese, 7 % of French and 7 % from other countries.

A research is on the way since the year 2002 to elucidate if this huge proportion of migrant population represents a risk for higher rates of psychotic disorder. The research was initially scheduled for 3 years but the low amount of patients in the first year will probably oblige us to add one more year . The main goal of this study is to compare the incidence and evolution of psychotic disorders among immigrants and native Andorrans through the follow-up of the patients attended at the Andorra Mental Health Services for a first psychotic outbreak. Our main hypothesis is that the incidence of psychotic disorder among immigrants will be significantly higher that the incidence among native Andorrans. We also hypothetize that the outcome of the disorder will be different in the sense of being more favourable in the group of immigrants. It is worth to see if the phenomena described in the migrant population of the United Kingdom, even with contradictory findings, can be ascertained in a very different society. We will take into account several cultural factors specific to the Andorran society. One important fact is that most of the Spanish immigrants come from the neighbouring autonomous region of Catalonia. This means that they share the same language, i.e., Catalan, the only official language of Andorra.. In fact, Andorra belongs to the cultural area called

"Catalan countries", much bigger than the strict area of Catalonia. This group of immigrants, obviously, can hardly be differentiated from the Andorran population from an ethnic point of view. The rest of Spanish immigrants come from other parts of Spain and might also speak other languages besides Spanish, like Galician or even Basque (a small minority). Galician is very close to Portuguese, the language of the second group of immigrants after the Spanish, the Portuguese. The third group, the French, speak, after all, a language also close to the mentioned so far. Except for Basque, they all are romance languages, issued from Latin and we can consider that, beyond the cultural particularities, all these groups also share a common southern European Latin culture.

But we have small minorities like the Moroccan immigrants, the Filipino group, the Indian group among others. It must be pointed that we have already had some cases of psychotic outbreak among these small groups which show clear ethnic differences. So, from an anthropological point of view, we might be confronted to a rather complex situation.

Due to the small global population it will probably be very difficult to draw conclusions from an epidemiological standpoint, so we will emphasize an in-depth analysis of ethnic aspects, turning to more ethnografic methods. This qualitative focus of the research will probably be more fruitful than the quantitative one in our case.

We hope to be able to present in about 4 years some data trying to shed some light about the controversial issue of migration and psychoses.

REFERENCES

[1] Stevens, J.R., Wyat, R. J. Similar incidence worldwide of schizophrenia: case not proven. *British Journal of Psychiatry*, 1987,151, 131-132.

[2] Kleinman, A: "Anthropology and Psychiatry. The role of culture in cross-cultural research on illness", *British Journal of Psychiatry* 1987, 151: 447-454.

[3] Cochrane, R. Mental illness in immigrants to England and Wales: an analysis of mental hospital admission 1971. *Social Psychiatry*,1987, 12, 25-35.

[4] Harrison, G., *et al*.: "A prospective study of severe mental disorder in Afro-Caribbean patients", *Psychological Medicine*, 1988; 18: 643-657.

[5] Dean, G., *et al*.: "First Admissions of Native-Born and Immigrants to Psychiatric Hospitals in South-East England 1976", *British Journal of Psychiatry*, 1981; 139: 506-512.

[6] Dein, S: "ABC of mental health: mental health in a multiethnic society", *British Medical Journal* 1997, 315: 473-6.

[7] Bhugra, D., et al.: "Incidence and outcome of schizophrenia in Whites, African-Caribbeans and Asians in London", *Psychological Medicine* 1997, 27: 791-798.

[8] Hutchinson, G., *et al*: "Morbid risk of Schizophrenia in First-Degree Relatives of White and African-Caribbean Patients with Psychosis", *British Journal of Psychiatry*, 1996, 169 (6): 776-80.

(9] Eagles, J. M.: "The Relationship Between Schizophrenia and Immigration. Are there Alternatives to Psychosocial Hypotheses?" *British Journal of Psychiatry* 1991; 159: 783-789.

[10] Sugarman, P. A. & Crauford, D. Schizophrenia in the Afro-Caribbean community. *British Journal of Psychiatry,* 1994. 164; 474-480

[11] Harrison, G., et al.: "Increased incidence of psychotic disorders in migrants from the Caribbean to the United Kingdom", *Psychological Medicine* 1997, 27: 799-806.

[12] Jablenski, 1992 (IPSS)

[13] Keh-Ming L, Kleinman AM. Psychopathology and clinical course of schizophrenia: a cross cultural perspective. *Schizophrena Bulletin* 1988;14:555-67. (14)

[15] Craig, T.J. et al "Outcome of schizophrenia and related disorders compared between developing and developed countries". *British Journal of Psychiatry* 1997, 170: 229-233

[16] McKenzie K, Van Os, J, Fahy, T, Jones, P, Harvey I, Toone, B. Murray R. Psychosis with good prognosis in Afro-Caribbean people now living in the United Kingdom. *British Medical Journal* 1995 331, 1325-1327.

[17] Callan, A. F.: "Schizophrenia in Afro-Caribbean Immigrants", *J R Soc Med* 1996, 89(5): 253-256.

[18] Harrison, G., et al.: "Increased incidence of psychotic disorders in migrants from the Caribbean to the United Kingdom", *Psychological Medicine* 1997, 27: 799-806
[19] Brekke, J. S., & C. Barrio: "Cross-ethnic symptom differences in schizophrenia: the influence of culture and minority status" *Schizophrenia Bulletin*, 1997; 23 (2): 305-316
[20] Bhugra, D., et al.: "Incidence and outcome of schizophrenia in Whites, African-Caribbeans and Asians in London", *Psychological Medicine* 1997, 27: 791-798.
[21] Birchwood, M, Cochrane R, MacMillan F, Copestake S, Kucharska J, Cariss M. The influence of ethnicity and family structure on relapse in first-episode schizophrenia. A comparison of Asian, Afro-caribbean, and white patients. *British Journal of Psychiatry* 1992, 161, 783-790
[22] Kennaway, E.L. Cancer of the liver in negroes in Africa and America. *Cancer Research* 1944,4, 571-577.
[23] Leff, J. A model of schizophrenic vulnerability to environmental factor. In *Search for the Causes of Schizophrenia* (eds H. Hafner, W.F. Gattaz & W. Janzarik). Berlin: Springer-Verlag,1987.
[24] Leff, J. What is the effect of migration? In *Psychiatry Around the Globe*: Transcultural View. London: Gaskell.1988
[25] London, M Mental illness among immigrant minorities in the United Kingdom. *British Journal of Psychiatry*, 1986,149, 265-273.
[26] Morrison, S.D. Intermediate variables in the association between immigration and mental illness. *International Journal of Social Psychiatry*, 1973, 19, 60-65.
[27] Westermeyer, J. Resuming social approaches to psychiatric disorder: a critical contemporary need. *Journal of Nervous and Mental Disease*, 1988, 176, 703-706
[28] Hare, E.H. Epidemiology of shizophrenia and affective psychoses. *British Medical Bulletin*, 1987,43, 514-530.
[29] Littlewood, R. & Lipsedge, M Acute psychoses reactions in Caribbean born patients. *Psychological Medicine*, 1981, 11, 303-318.
[30] Creed, F. Immigrant stress. *Stress Medicine* 1987, 3, 185-192
[31] Mc Govern, D. & Cope, R.V. First psychiatric admission rate of first and second generation Afro Caribbeans. *Social Psychiatry*, 1987, 22, 139-149.
[32] Littlewood, R. & Lipsedge, M. Psychiatric illness among British Afro-Caribbeans. *British Medical Journal*, 1988,296, 950-951.
[33] King, M., Coker, E., Leavey, G. Hoare, A., Johnson-Sabine, E. Incidence of psychotic illness in London: comparison of ethnic groups. *British Medical Journal* 1994, 309: 1115-19.
[34] Jacobs, S. & Myers, J. Recent life events and acute shcizohprenic psychosis: a controlled study. *Journal of Nervous and Mental Disease*, 1976, 162, 75-87.
[35] Chung, R.K., Langeluddecke, P. & Tennant, C. Threatening life events in the onset of schizophrenia, schizophreniform psychosis and hypomania. *British Journal of Psychiatry*, 1986, 148, 680-685
[36] Gureje, O. & Adewunmi, A. Life events and schizophrenia in Nigerians: a controlled investigation. *British Journal of Psychiatry*, 1988, 153, 367-375.
[37] Eagles,J.M. The relationship between schizophrenia and immigration. Are there alternatives to psychosocial hypotheses ? *British Journal of Psychiatry,* 1991,159, 783-789
[38] Stevens, J.R. and Wyatt, R.J. Similar incidence worldwide of schizophrenia: case not proven.. *British Journal of Psychiatry*, 1987, 151, 131-132
[39] Cochrane, R. & Bal, S.S. Migration and schizophrenia: an examination of five hypotheses. *Social Psychiatry*, 1987, 22, 181-191.
[40] Harvey, I.., Williams, M., Mc Guffin, P. Toone, B.K. The functional Psychoses in Afro-Caribbeans. *British Journal of Psychiatry*, 1990; 157: 515-522.
[41] Odegaard, O. Emigration and insanity. *Acta Psychiatrica Scandinavica*. 1932,Supplement 4
[42] Mednick, S.A., Machon, R.A., Huttanen, M.O., et al . Adult schizophrenia following prenatal exposure to an influenza epidemic. *Archives of General Psychiatry*, 1988, 45, 189-192.
[43] Watson, C.G., Kucala, T., Tilleskjor, C., et al Schizophrenic birth seasonality in relation to the incidence of infectious diseases and temperature extremes. *Archives of General Psychiatry*, 1984, 41, 85-90.
[44] Torrey, E.F. Prevalences studies in schizophrenia. *British Journal of Psychiatry*, 1987[a], 150, 598-608.
[45] Wing, J.K. Shizophrenic psychoses: causal factors and risks. In: The Scope of Epidemiological Psychiatry (eds. P. Williams, G. Wilkinson, K. Rawnsley). London: Routledge 1989.
[46] King, D.J., Cooper, S.J., Earle, J.A.P., et al Serum and CSF antibody titres to seven common viruses in schizophrenic patients. *British Journal of Psychiatry*, 1985, 147, 145-149.
[47]) Jacobsen, B. D.K. Kinney Perinatal complications in adpoted and non-adopted schizophrenics and their controls: preliminary results. *Acta Psychiatrica Scandinavica,* 1980 (suppl 285), 337-346.

[48] Parnas, J. Schulsinger, F. Teasdale T.W. et al. Perinatal complications and clinical outcome within the schizophrenic spectrum. *British Journal of Psychiatry,*1980, 140, 416-420.
[49] Lewis, S.W., Murray, R.M. Obstetric complications, neurodevelopmental deviance and risk of schizophrenia. *Journal of Psychiatric Research,* 1987,21, 413-421.
[50] Eagles, J.M., Gibson, I,, Bremner, M.H.. Obstetric complications in DSM-III schizophrenics and their siblings. *Lancet*, 1990, 335, 139-1141.
[51] Wilcox, J.A., Nasrallah, H.A. Perinatal insult as a risk factor in paranoid and non-paranoid schizophrenia. *Psychopathology*, 1987,20, 285-287.
[52] Schwarkopf, S.B. Nasrallah, H.A., Olson, S.C. Preliminary complications and genetic loading in schizophrenia: preliminary findings. *Psychiatry Research*, 1989, 27, 233-239.
[53] DeLisi, L.E. Smith, S.B., Hamovit, J.R. et al. Herpes simplex virus, cytomegalovirus and Epstein-Barr virus antibody titres in schizophrenic patients. *Psychological Medicine*, 1986, 16, 757-763.
[54] Owen, M.J., Lewis, S.W. Murray R.M. Obstetric complications and schizophrenia: a computed tomographic study. *Psychological Medicine*, 1988, 18, 331-339.

CULTURAL PSYCHIATRY AND SERVICES ORGANIZATION: IS THE CANADIAN MODEL APPLICABLE TO THE ITALIAN CONTEXT?

Vittorio De Luca[1], Vincenzina Iannibelli[1], Micol Ascoli[2]

[1] Servizio Speciale di Psichiatria e Psicoterapia, Università "La Sapienza", (Roma, Italia).
[2] Istituto Italiano di Igiene Mentale Transculturale (Roma, Italia)

Correspondence: Dr. Vittorio De Luca, Università di Roma "La Sapienza", Via Panama 68/70 00197 Rome, Italy. Tel: +39 (06) 8555497 Fax: +39 (06) 8542731
E-mail: vittorio.de_luca@uniroma1.it

ABSTRACT

The scope of this paper is to compare the transcultural psychiatry current organization in Italian institutions with public services provided in a Western multicultural society, the Canadian one. Such a comparison emerges from the on-field experiences through the Italian and Canadian public mental health services, and its aim is to evaluate the differences on the legislative and institutional fields, as well as the clinical and epidemiological ones.

An historical comparison of the transcultural psychiatry evolution in the two countries is proposed by the Authors, and such evolution is analyzed across the sociological, historical and cultural differences. The presence of a radically multicultural society, indeed, profoundly determined the birth and development of Canadian transcultural psychiatry services, as well as the particular characteristics of this society provoked a special relationship with the linguistic and cultural "diversity": what resulted was a totally extraordinary policy of approaching the "different", even compared with other multiethnic country as United States; such policy has been the very basis for both transcultural psychiatric theory and practice.

On the contrary, the organization of Italian transcultural psychiatry clinical services seems to represent a relatively little, or non-multiethnic society, even though Italian current society shows a milieu culturally more differentiated than institutions appear to acknowledge. The reasons of this unaccomplished evolution are explored by the Authors across the historical and sociological premises underlying the constitution of psychiatry public services.

The results yielded from this analysis track the line for a possible transcultural psychiatry future evolution, due both to the north-American model influence and the presented specific characteristics of the Italian society.

1. INTRODUCTION

Mental health services organization is nowadays a noteworthy issue for health professionals, public managers and the community, and it has become subject for debates and theoretical considerations in order to realize structures representing collective values and satisfying clients' needs.

2. PSYCHIATRY AND CULTURES IN ITALY

Mental Health Services and Italian cultural values

The introduction of so-called "Basaglia's Law" (Public Law 180/78, the Italian law on Deinstitutionalization) represented a revolution in the way of conceiving mental illness and the relationship between the mentally ill and the society; moreover, it also corresponded to the realization of an ideological movement starting from a number of cultural transformations that occurred in Europe and North America since some decades [1].

As a recent Italian movie tried to show[1], one can say that not only did Basaglia's Law represent a set of rules for the practice of a particular health profession, but it also symbolized some cultural values of that particular society, which intended to give psychiatric patients back their dignity and place within the community; in turn, the community regarded itself capable to receive those patients [2].

Psychiatric services organization, thus, represents an interesting issue in Italy, in order to understand, how much importance the society gives, at least theoretically, to the assistance of a particular kind of disadvantaged people, the mentally ills.

[1] "La meglio gioventù" directed by Marco Tullio Giordana (2003)

The actual incomplete application of Basaglia's Law, and the constant need to revise it (an issue debated since more than a decade, recently made concrete through the Parliament debating so-called Burani-Procaccini's bill) represent in turn different values and needs of Italian society, that did not consider financing mental health institutions for a very long time.

Should we describe actual Italian mental health services by a metaphor, we could represent them as a meeting point between two different movements: the first towards mental health's democratization, through the patient being given back their rights and dignity, and being put back in their place within society; the second towards a very slow acknowledgment of the specific needs of territorial and social services, which should have given patients assistance and treatment for a decent life.

Moreover, the ability to acknowledge the needs of community itself seems even slower, as it often remains without any cultural, nor economical means to support psychiatric patient.

These two movements, and their different speed, explain most of the difficulties run into by the two principal characters (the patient and the community), while trying to meet and live in decent harmony, notwithstanding the role played by the mental illness itself within this process.

Solitude of Italian transcultural psychiatry

At this point, even the establishment and organization of transcultural psychiatric services could be considered a sensitive mirror of needs and values underlying the relationship between society and a different distressed party, the foreigner mentally ill, combining therefore double "diversities". The more diverse one is, the less he is able to communicate needs and distress, and to be acknowledged his own dignity and rights.

In Italy, this "meeting the diverse" started in the '50s in the Universities first, as a research. One can say that Italian psychiatry, just like the international one, started being interested in cultural factors seeking privileged meeting point far away, in the "exotic" context. No matter if the exotic was conceived geographically, like Far East or Africa, or temporally, like those places in Italy, that seemed to be still living a different century, namely some Southern villages [3]. However it was understood, this "meeting the diverse" produced noteworthy and original theoretical considerations [4]. In some decades, the interest in cultural factors made some Universities establish so-called "transcultural units" [5], whose field of interest still was research, especially theoretical one (Turin and Rome, for instance).

The next step was the attempt to translate into Italian society itself, that interest in cultural factors which drove the first researches. A first experiment was conducted in Rome in 1979 under the guidance of L. Frighi: it lately brought to the collaboration with some Catholic volunteers and the establishment of Roman Caritas Outpatient Department in Via Marsala, a center now delivering some 20,000[2] services per year, 3-4% of which within the mental illness area (typically psychopharmacological services). It is already possible to note, in this example, how Italian transcultural psychiatry is not only conditioned by the stimulus to theoretical and clinical research, but also by the necessary compromise with those volunteer associations, that historically translated the first contact with distressed foreigners into the form of Catholic relief.

Nowadays, there should be some 2,4 millions regular foreign people in Italy[3], which represent around 4% of Italian population. So far, this presence determined two different tendencies. The first is a kind of "siege mentality" characterized by fear of being overwhelmed by an increasing number of foreigners. This tendency was encouraged even recently by some political exponents and sometimes even clergymen, who claimed that increasing foreigners would threaten Italians' wealth, safety and cultural identity (conceived as historical tradition, but also as legacy of Christian values). Contemporarily, a second tendency determined that civil society "forget"

[2] Source: Caritas Rome (2002).
[3] Source: Caritas Rome based on data from Italian Ministry of Internal Affairs (2003).

totally to allow immigrants health care and other public services by using different languages, interpreters and *adjustments* to foreign cultures. Transcultural psychiatry, thus, represents this situation, an "academic" or "volunteer" practice much more than a practical translation of needs and values of a society admitting its "diversity". One can say that, in Italy, meeting the diverse is marked by feelings of fear and loss of control (which really are the basis of "siege mentality - not a supposed overwhelming presence of foreigners) as well as by the need of defending oneself from the accuse of "racism", that justifies the lack of specific structures organized or managed by the state, as they could be accused to be "marginalizing". The result is a typical process of negation: the negation of one's own cultural reality (which would not be seen in danger if it were seen as a valid one) and historical legacy (which is always a product of many previous "differences" and "distances"); but also the negation of historical and cultural "other's" reality, seen between the two edges of threaten and not-existence, not-diversity, both justifying not only the missed encounter, but also the missed acknowledgement of needs and rights.

Transcultural psychiatry could therefore be seen as a force counteracting this particular kind of negation, a countercurrent tendency against the general movement of society, and a sort of "subversive" element [6]. Yet more the expression of an elite culture than of national values and needs.

3. PSYCHIATRY AND CULTURES IN CANADA

Birth of Canadian cultural psychiatry

R. Prince describes in a recent paper [7] the particular atmosphere when Section of Transcultural Psychiatry Studies was established in 1955 by E. Wittkower, on the advice of D. E. Cameron, at Department of Psychiatry, McGill University. Prince cites H.B.M. Murphy who used to argue that Canadian society and its specific values, allowing the same dignity two different languages and cultures, were the necessary premises for the development of an attitude sensitive to different cultures; he also outlines the biographies of the different people contributing to the development of the Division of Social & Transcultural Psychiatry, describing how there was a history of migration, intertwining different cultures and, often, profound suffering due to this process in everyone's background. And it does not seem a coincidence that minds so sensitive to problems connected to migration and refugee status, ended up in a country expressly receptive to and respectful of cultural identities, as Canada was.

Health services and Multiculturalism in Canada

The organization of Canadian psychiatric services for foreign people is the mirror of both Canadian model of citizenship and the values enshrined in Canada Health Act, the national health care policy. L.J. Kirmayer and H. Minas [8] described recently how models for health care reflect the concept of citizenship, conceived as the relationship between cultural and ethnic diversities characterizing citizens in the same State. They describe Canadian citizenship as Multicultural, referring to Castels and Millers' distinction between imperial, republican, ethinc and multicultural models [9]. A multicultural model is defined as a community sharing a common constitution and law, but not a single cultural model, allowing ethnic communities to develop their traditions and values.

Even though this policy initially moved from the need to counteract Quebec's separatism and increasing politicization of minorities, it ended up stating officially that "although Canada has two official languages, there is no official culture, nor does any ethnic group take precedence over any other". The policy identified some 80 different ethnic or cultural groups which could apply for financial support from various ministries, to support programs for developing and maintaining cultural and linguistic identity [10]. Some Authors point out that official

multiculturalism allowed actually only a folk or linguistic acknowledgment, while the very center of political power was not made accessible to minorities [11]. However, following acts clarified, theoretically at least, the importance of cultural diversity within Canadian society: the 1982 Charter of Rights and, especially, the 1988 Canadian Multiculturalism Act, which promoted "full and equitable participation of individuals and communities of all origins in the *continuing evolution and shaping of all aspects of Canadian society*", and "assisted them in the elimination of any barrier to such participation".

In the same time Canada was defining a model of health care based on 5 fundamental principles: full accessibility to services, universality of coverage, portability through space and time, total comprehensiveness of services, and public administration. This process started in 1957 (Hospital Insurance and Diagnostic Services Act), goes through the first Medical Care Act (1966) and following Canada Health Acts. The last stage of this process is the document produced by Romanow Commission [12], declaring that these fundamental principles are even more important for Canadian society and Medicare is more an ethical enterprise that an economical or political issue.

Although theoretically sharing all 5 Canadian Medicare principles, Italian National Health Service shows many differences from Canada, for the concept of Health Insurance and public service. Even more different is the application of this policy to mental health, where Deinstitutionalization resulted in the development of Territorial Services in Italy, and Community services in Canada. This is not only a matter of words: in the one case the burden of patient management is given principally to decentralized outpatient department (no public alternative being possible), in the other case outpatient management is delivered by General Hospital Units, GPs or private professionals (for whom patients are insured by Medicare) and local organizations are involved principally in social needs and general medicine, that in Quebec are delivered by the same structure, the CLSC. According to some Authors, however, psychiatric management is still far from finding encouraging answers, especially due to the slowness in financing decentralized structures [13].

Mental health services for Canadian society

We said that Canadian cultural psychiatry stands over two ideological pillars, Multiculturalism and national health insurance (Medicare). Multiculturalism represents the framework around the interest for cultural diversity, and the definition of citizenship. Medicare represents the ideology through which all citizens must be given the same accessibility to health services. The translation into practice of these strong ideologies is not, currently, given for granted: the choice between establishing ethnopsychiatric services and responding to cultural diversity within the mainstream is still issue for debates in Canada; in a recent Conference at McGill University, Montreal[4], many good examples of both tendencies were cited. One of the Authors focused his experience into understanding of the second model, that inspired the establishment of a Cultural Consultation Service in Montreal.

According to this model [14], a unit composed by anthropologists, psychiatrists and clinical psychologists trained in cultural psychiatry, provided consultations for any professional or structure responsible for the management of patients with culturally different background. The service works with a network of culture brokers expert in many cultures, and with a database of community organizations to put in touch with the patients when needed. Specific training allows health care providers to make a correct diagnostic assessment and a cultural formulation, and to correct possible errors in patients' psychiatric treatment and assistance. Giving patients back their possibility to access general services and linking them to specific community organizations is double way to apply Medicare's principle of accessibility. Moreover, establishment of a unit for

[4] "Models of Mental Health Services for Multicultural Societies", Montréal, June 2-3, 2003.

all different cultural groups is the most economical and effective translation of the public administration principle, that make the establishment of public transcultural units for every specific cultural group improbable to be realized.

4. CONCLUSION

Although far from being without difficulties and contradictions, Canadian experience allowed the development of transcultural psychiatry services able to try an encounter with cultural diversity and to provide a space for the correct management of patients bearing this diversity. It seems hard to imagine the development of similar structures in countries where health care does not have so strong a commitment for accessibility to services. Even countries, like Italy, sharing a similar commitment, this is not enough. The ideological framework of multiculturalism gives the social and economical warranty, that volunteer vocation or cultural elite's interest alone cannot give. The Italian example is still useful to understand how the cultural profile of theoretical research is not enough for the establishment of concrete and useful clinical services, even though some Authors outlined also guidelines for training professionals in culturally sensitive psychiatric practice [15]. Experiences like Italian Mental Health Institute in Rome, Franz Fanon Center in Turin, NAGA and Cecchini-Pace Foundation in Milan are interesting, yet they all bear the burden of a partial failure, due to lack of visibility, economical funding or linkage to institutions. Mental health models still need premises like shared cultural values (that is to say attention and sensitiveness to culturally diverse, in this case), to be applied within the society. The only possibility of introducing a culturally sensitive model of mental health care, at this moment, is to acknowledge cultural and ethnic diversity, considering more the value of multiculturalism.

ACKNOWLEDGMENTS

We are grateful to Laurence J. Kirmayer, G. Eric Jarvis and the whole Division of Social and Transcultural Psychiatry, McGill University for the possibility offered to one of the Authors of attending and working within their Service. A special thanks to Antonia Maioni for advises about Canadian public health. At last, a particular thanks to Goffredo Bartocci, Nicola Lalli and Vittorio Infante, for suggestions and advises about the historical evolution of Italian transcultural psychiatry.

REFERENCES

[1] L. Burti, P.R. Benson, "Psychiatric reform in Italy: developments since 1978", *International Journal of Law and Psychiatry*, vol. 19, 1996, pp. 373-390.
[2] N. Scheper-Hughes, A. M. Lovell, "Breaking the circuit of social control: lessons in public psychiatry from Italy and Franco Basaglia", *Social Science and Medicine*, vol. 23, 1986, pp. 159-178.
[3] E. De Martino, *Sud e Magia*, 1959, Feltrinelli Editore Milano, pp. 205.
[4] E. De Martino, *Il mondo magico. Prolegomeni a una storia del magismo*, 1957, Bollati Boringhieri Torino, pp. 274.
[5] G. Bartocci et al., "Transcultural psychiatry. An investigation of acute symptoms in two radical groups", *Lavoro neuropsichiatrico*, vol. 56, 1975, pp. 17-38.
[6] R. Beneduce, "Creolizzazione, conflitto sociale ed etnopsichiatria", *I fogli di Oriss*, n. 7/8, 1997, pp. 123-132.
[7] R. H. Prince, "Transcultural psychiatry: personal experiences and Canadian perspectives", *Canadian Journal of Psychiatry*, vol. 45, 2000, pp. 431-437.
[8] L.J. Kirmayer, H. Minas, "The future of cultural psychiatry: an international perspective", *Canadian Journal of Psychiatry*, vol. 45, 2000, pp. 438-446.
[9] S. Castels, M.J. Miller, *The age of migration: international population movements in the modern world*, 1998, Guilford New York.
[10] E. Mackey, *The house of difference. Cultural politics and national identity in Canada*, 2002, University of Toronto Press, pp.216.
[11] J. Rex, "Multiculturalism in Europe and North America", *Nations and Nationalism*, vol. 1, 1995, pp. 243-259.
[12] Commission on the future of Health Care in Canada, *Building on Values: the Future of Health Care in Canada*, 2002.
[13] P. Goering, D. Wasylenki, J. Durbin, "Canada's Mental Health System", *International Journal of Law and Psychiatry*, vol. 23, 2000, pp. 345-359.
[14] L. J. Kirmayer, D. Groleau, J. Guzder, C. Blake, G. E. Jarvis, "Cultural Consultation: a model of mental health service for multicultural societies", *Canadian Journal of Psychiatry*, vol. 48, 2003, pp. 145-153.
[15] G. Bartocci, "Linee orientative ed organizzative per l'assistenza psichiatrica nell'ambito dei Servizi Pubblici" in Geraci S. (a cura di), *Medicina e migrazioni*, 1992, Presidenza del Consiglio dei Ministri, Roma.

CULTURAL IDENTITY, ACCULTURATION AND MENTAL HEALTH A SCHOOL BASED POPULATION STUDY OF ADOLESCENTS IN EAST LONDON

Kamaldeep Bhui, MD[1]
Stephen Stansfeld, PhD[1]
Jenny Head, MSc.[1,3]
Mary Haines, PhD.[1]
Sheila Hillier, PhD.[1]
Stephanie Taylor, PhD.[1]
Russell Viner, PhD.[2,3]
Robert Booy, PhD.[1]

[1]Barts & London Medical School,
Institute of Community Health Sciences,
Queen Mary University of London.

[2]Great Ormond St Hospital, London.

[3]University College London.

Institute of Community Health Sciences,
Queen Mary,
London E1 4NS
Tel 02078827842
Fax: 02078827924
Email: k.s.bhui@qmul.ac.uk

ABSTRACT

Background: Although studies of migration and mental health among adults are common, few studies have looked at acculturation, cultural identity and risks to the mental health of adolescents. Adolescent mental health problems are antecedants of adult and adolescent mental disorder. Cultural identity as a risk factor receives scant attention in population studies, and may be an important risk factor.

Methods: We surveyed 2623 adolescents from two year groups (aged 11-14) from a representative sample of 28 inner city schools in London. Mental health problems were measured with the Strengths and Difficulties Questionnaire. Pupils were classified into one of four identity types (integrated, traditional, assimilated and marginalised) on two behavioural domains: friendship and clothing choices.

Results: Data on 2623 pupils from 9 ethnic groups show that, in comparison with marginalised adolescents, adolescents with traditional and integrated friendship choices have fewer mental health problems. The effect is especially marked among girls. In contrast, only boys with integrated friendship choices were less likely to have mental health problems. Integrated clothing choice was associated with better mental health, but only among girls. Sub-group analyses showed that Bangladeshi pupils with integrated friendship choices had the lowest levels of mental health problems.

Conclusion: Friendship and clothing choices, when understood as expressions of identity, may be aetiological risk factors for mental health problems.

INTRODUCTION

Adolescence is a vulnerable period of development that involves a confusion of identity (1). Attachment to people and places leads to a stable place identity that is threatened by migration and displacement (2). Adolescent mental health problems are disabling, but also affect personality development and may lead to mental disorder in adulthood. In the face of unpredecented levels of migration, and the recognition that most adolescents in urban areas mature in multicultural communities, the effects of acculturation on mental health become important. Acculturation is defined as 'the phenomena which results when groups of individuals having different cultures come into continuous first hand contact with subsequent changes in the original cultural patterns of either or both groups' (3). Although often discussed in terms of culture shock, acculturation also affects identity, behaviour, self-concept, world-view and illness models. Comparative studies of the impact of acculturation on the mental health of adolescents from different ethnic groups are uncommon (4). In the UK, acculturation has received significant attention following racial riots in the inner cities where White British and South Asian youth live in segregated neighbourhoods. International attention to asylum seekers, refugees, immigration and terrorism fuels debate about citizenship, national identity, and integration policies for new migrants. These issues make the health impacts of acculturation a priority (5) (6) (7) (8) (9) (10).

METHODS

Design and sample selection

We conducted a cross-sectional school-based epidemiological study of a representative sample of 2 790 adolescents from Year 7 (11-12 years) and Year 9 (13-14 years) attending 28 schools in East London in 2001. All forty-two eligible schools in the three geographically defined London boroughs were stratified by borough and school type (comprehensive; voluntary; other). Thirty schools were randomly selected and balanced to ensure representation by single sex or mixed sex as well as ethnicity, school size and deprivation. Within schools that agreed to take part four representative mixed ability classes were selected (two from year 7 and two from year 9). The overall response rate was 84%. Adolescents completed a survey questionnaire whilst in class and with help, where necessary, from the research team. The local research ethics committee approved the study.

Mental Health Measures

Mental health was measured using the self report 'Strengths and Difficulties Questionnaire' (SDQ), a psychometrically valid instrument that was previously used in two large surveys of young people (32;33;34). A total difficulties score (0-40) is derived by summing four sub-scale scores (emotional symptoms, conduct problems, peer problems, hyperactivity). Young people were considered to have 'mental health problems' if they scored 17.5 or more, a threshold that is based on scores in national data where 10% (9.4% boys, 9.0% girls) of the sample scored within the 'high scorer' band (33).

Ethnicity and Culture Indicators

Ethnic group was classified by self-report using ethnic categories from the 2001 UK census, supplemented by questions on national group. In this paper we report data on the nine largest ethnic groups: White UK, White-other, Mixed race (parents were White and of other origin), Indian, Pakistani, Bangladeshi, Black Caribbean, Black African, Black British. Choice over food, friends, leisure pursuits and clothes are important sources of variation in identity (19). In this

study we chose two domains that are explicit external expressions of identity among young people: choice of friends and choice of clothes. Although previous studies have emphasised cultural identity of black and minority ethnic migrants, the cultural identity of white adolescents, especially if they are a minority, is also of interest as minority status confers a greater risk of mental disorder (35). We therefore designed the questions to be suitable for adolescents from any ethnic group. We piloted the questions and conducted debriefs to ensure face and content validity, and to maximise response rates by improving the clarity and ease of completion of the questionnaire. Although we wished to use the term 'culture' in the questionnaires, the term 'race' was used instead as as the pilot studies and debriefing showed that adolescents were unable to make sense of the words 'culture' or 'ethnic group'. Adolescents understood the word 'race' and its relationship to skin colour, lifestyles, food, dress and religion, that is, cultural elements were incorporated in their use of the term race. As proxy measures for cultural identity we assessed pupil's choices of friends and of clothing on a four-item likert response scale to each of four questions (Figure 2). The responses were used to classify pupils according to Berry's identity categories (30). This classification includes integration (strong identification with own cultural group and other cultural groups), assimilation (strong identification with other cultural groups but not one's own), traditionalism (strong association with own cultural group but not other group), and marginalisation (strong identification with neither own nor other cultural group). The specific questions used to assess cultural identity (Annex 2) were asked following the section committing each subject to a particular ethnic group. Each question had had four possible responses (score between 1 and 4). These were re-coded into binary variables using a threshold score of 2 or less to designate weak endorsement of each statement. Those scoring 3 or more were classified as strongly endorsing each statement. This binary measure indicated weak or strong identification with 'own' (questions 1 and 3) and 'other' groups (questions 2 and 4). These variables were combined to generate four groups of pupils (Box 1), for each domain (clothing and friendship choices). We also asked questions about speaking English or another language.

Analyses

Statistical analyses were weighted to take account of unequal probabilities of selection. As the sample used a stratified cluster design with pupils clustered within schools, standard errors and 95% confidence intervals for means and proportions were calculated using survey estimation (svy & cluster) commands available in STATA 5.0. This produces robust standard errors for the sampling strategy. Potential confounds included year group, school, borough, eligibility for free school meals (as a measure of household income), gender and ethnic group. We also stratified by gender, and by specific ethnic groups. In order to reduce chance findings from multiple significance tests in ethnic group sub-analyses, we only reported findings reaching a statistical significance of $p<0.01$. In regression models the marginalised group was always the reference group. A gender by year group interaction was included in the final model as girls were more likely to be in year nine than seven (OR=1.57, 1.01 to 2.42, p=0.04).

RESULTS

The Sample

The ethnic groups were White UK (581), White-other (161), mixed white-other (191), Indian (250), Pakistani (184), Bangladeshi (690), Black Caribbean (166), Black African (279) and Black British (121). Twenty percent (n=525) of adolescents were born outside of the UK. Of the 514 adolescents not born in the UK, 39% had been in the UK for less than 5 years, 28% for between 6 and 10 years, 29% for less than 10 years and 4.5% almost all their lives. We asked about religion: 555 (21.3%) expressed not having a religion, 678 (26%) were Christian, 1137 (43.6%) were

Muslim, 87 (3.3%) were Hindu, 68 (2.6%) were Sikh and 82 (3.2%) either did not know, or gave another religious group (n=30). Only 2% of pupils spoke no or little English at school. Elibility for free school meals varied from 22% of Indian adolescents to 66% of Bangladeshi adolescents.

Cultural Identity

Tables 1 reports the identity choices for each ethnic group. Bangladeshi pupils had the most traditional friendship choices. South Asian groups (Bangladeshi, Pakistani and Indian) were the least integrated. Approximately 40% of white and black children had both same-cultural and cross-cultural (integrated) friendship choices. A large proportion of all young people had clothing choices reflecting non-identification with own or other cultural groups (marginalised). On the basis of clothing choices, in comparison with the marginalized group, girls were more likely to be classified as 'traditional (OR=1.48, 1.2 to 1.84, p<0.001) with a near significant trend for being more likely to be assimilated (OR=1.29, 0.99 to 1.68, p=0.06; see Table 2). Gender was not significantly associated with cultural identity classification on the basis of friendship choice.

Our approach assumed the two domains, clothing and friendship choices, were independent measures of cultural identity. This was supported by a lack of agreement between the classification of cultural identity based on clothing choices and classification based on friendship choices (overall kappa=0.12). The pilot studies supported the face and content validity of the measures. As a test of concurrent validity we assessed whether speaking English at home was related to specific patterns of clothing and friendship choices. In comparison with adolescents with marginalized choices, adolescents not speaking English at home were more likely to have traditional friendship choices (OR=1.5, 1.19 to 2.0, p=0.001), were less likely to have assimilated (OR=0.53, 0.39 to 0.72, p<0.001) and integrated (OR=0.72, 0.56 to 0.93) friendship choices, but surprisingly, were less likely to have traditional clothing choices (OR=0.78, 0.63 to 0.97, p=0.03).

Levels of Mental Health Problems

Religious group was not associated with mental health problems, whilst those born out of the UK were 1.3 times more likely to have a mental health problem (95%CI: 1.02 to 1.7, p=0.04). In adjusted analyses mental health problems were least likely among adolescents making integrated or traditional friendship choices, and among adolescents making integrated choices in clothing (Table 3). The findings held despite adjustment for all confounds, and adjustment for ethnic group (Table 3). The findings were not changed by adjustment for religion, being born outside of the UK, or years spent in the UK. Adolescents with assimilated clothing choices had the highest risk of mental health problems; adjustment for confounds made little difference to the odds ratios.

Gender Effects

Girls were more likely to have mental health problems (227/1104 vs 178/1075; OR=1.3, 1.04 to 1.56, p=0.02). On stratifying by gender and adjusting for confounds, lower levels of mental health problems were found among girls with traditional (OR= 0.47, 0.29 to 0.75, p=0.002) or integrated patterns of friendship choices (OR=0.59, 0.37 to 0.92, p=0.02), and among girls making 'integrated' clothing choices (OR=0.5, 0.3 to 0.83, p=0.007).

Ethnic group effects

We stratified by the three largest aggregated ethnic groups (Asian, White, Black), to assess whether the findings differed according to ethnic group. Only two findings were highly significant. On friendship choices, integration was protective only among south Asians (OR=0.38 95%CI: 0.21 to 0.69, p=0.002), and Bangladeshi pupils (OR=0.3, 95%CI: 0.15 to 0.78, p=0.01).

CONCLUSIONS

We conclude that traditionalism and integration, in terms of friendship choices, may confer some protective effect for all cultural groups, especially for girls. Our data suggest that a brief inventory about friendship choices is a useful measure of identity, but clothing choices are more complex, and may suffer from constraints due to contextual expectations. Gender roles, and their interaction with cultural identity changes during acculturation require more in depth study. Prospective studies are required to establish the strength of protective effects and to address problems of reverse causality found in cross sectional studies.

TABLE 1: PERCENTAGE OF EACH ETHNIC GROUP FALLING WITHIN SPECIFIC ACCULTURATION LEVELS

		White	White Other	Mixed	Indian	Bangladeshi	Pakistani	Black Caribbean	Black African	Black British
Friendship		n=529	n=116	n=165	n=231	n=601	N=165	n=133	n=243	n=110
Choices	*% Resp. Rate**	*91*	*72*	*86*	*92.5*	*87.1*	*89.7*	*80.1*	*87.1*	*90.9*
	Marginalised	14.8	20.1	19.6	17.4	14.1	17.1	11.8	17.8	13.4
	Traditional	29.4	15.8	17.1	22.9	52.5	37	31.8	20.2	25.7
	Assimilated	16.6	27	34.3	30.8	5.6	12.1	15.1	20.7	21.3
	Integrated	39.1	37.1	30	29	27.8	33.8	41.4	41.3	39.5
Clothing	Responders	n=527	N=116	n=164	n=231	n=601	n=164	n=131	n=234	n=111
Choices	*% Resp. Rate**	*90.7*	*72*	*85.9*	*92.4*	*87.4*	*98.8*	*71.2*	*83.9*	*91.7*
	Marginalised	33	47.1	37.8	37.4	38.1	38.1	32.2	41.1	36.0
	Traditional	36.1	17.9	23.9	21.1	21.1	29.6	27.8	21.8	23.7
	Assimilated	5.0	10.4	17.5	20.4	16.9	13.7	11.1	18.6	17.4
	Integrated	26.3	24.6	20.8	21.1	24	18.7	28.9	18.6	22.9

* Response rate to cultural identity questions

TABLE 2: MENTAL HEALTH PROBLEMS: IDENTITY AND GENDER

		Girls	Boys
Identity choices	Identity Types	SDQ cases n/N (%)	SDQ cases n/N (%)
Clothing Choices	Marginalised	71/416 (17.4)	55/429 (12.4)
	Traditional	51/350 (14.9)	35/241 (14.6)
	Assimilated	42/170 (24)	20/140 (14.2)
	Integrated	27/256 (10.5)	31/270 (11.0)
Friendship Choices	Marginalised	43/195 (22.7)	29/164 (17.1)
	Traditional	47/377 (12.4)	44/366 (11.6)
	Assimilated	45/234 (19)	25/157 (15.6)
	Integrated	57/389 (14.9)	43/386 (10.9)

TABLE 3: ACCULTURATION AND MENTAL HEALTH: LOGISTIC REGRESSION MODELS WITH STRENGTHS AND DIFFICULTIES QUESTIONNAIRE 'CASENESS' AS OUTCOME

		Friendships			Clothing		
		OR	95%CI	p value	OR	95%CI	p value
Unadjusted	Marginalised	1			1		
	Traditional	0.54	0.38 to 0.76	<0.001	0.99	0.73 to 2.35	0.97
	Assimilated	0.85	0.58 to 1.23	0.38	1.40	1.0 to 1.97	0.05
	Integrated	0.59	0.41 to 0.82	0.002	0.69	0.50 to 0.97	0.03
Age +	Marginalised	1			1		
Gender by	Traditional	0.53	0.38 to 0.75	<0.001	0.97	0.72 to 1.32	0.87
Year group	Assimilated	0.83	0.57 to 1.20	0.37	1.40	1.0 to 1.98	0.05
Interaction	Integrated	0.59	0.42 to 0.83	0.002	0.70	0.50 to 0.98	0.04
Above +	Marginalised	1			1		
Eligibile for	Traditional	0.54	0.37 to 0.76	<0.001	0.96	0.70 to 1.31	0.77
Free school	Assimilated	0.82	0.58 to 1.21	0.33	1.37	0.96 to 1.96	0.08
Meals	Integrated	0.58	0.41 to 0.82	0.002	0.69	0.48 to 0.98	0.04
Above +	Marginalised	1			1		
Ethnic	Traditional	0.57	0.40 to 0.82	0.003	0.93	0.68 to 1.27	0.64
Group	Assimilated	0.77	0.52 to 1.13	0.19	1.44	1.0 to 2.06	0.05
	Integrated	0.57	0.40 to 0.82	0.002	0.67	0.47 to 0.96	0.03

Annex 1: Cultural Identity Questions

Question 7 on page 4 asked you about your **race or ethnic group.**

- The following questions are about how similar or different you feel from people in your **race or ethnic group**.
- Try and answer all of the questions.

---

57. *Is your choice in **clothes similar** to people from **your** **race/ethnic group**?*

❑1 No
❑2 A little like them
❑3 Quite a lot like them
❑4 Mostly like them

58. *Is your choice in **clothes similar** to people from **other** **races/ethnic groups**?*

❑1 No
❑2 A little like them
❑3 Quite a lot like them
❑4 Mostly like them

59. *Do **you have** many **good friends** who belong to **your** **race/ethnic group**?*

❑1 None
❑2 Some
❑3 Quite a lot
❑4 Most or all of them belong to my own race / ethnic group

60. *Do **you have** many **good friends** who belong to **other** **races/ethnic groups**?*

❑1 None
❑2 Some
❑3 Quite a lot
❑4 Most or all of them belong to other races / ethnic groups

History

- Kraeplin's visit to Java (Kraeplin 1904)
- International Pilot Study on Schizophrenia (IPSS)
- Determinants of Outcome of Severe Mental Disorder (DOSMD, "10 country study")
- Migrant studies (e.g. Selten et al., 2002)

Consistency of high incidence findings among immigrants

Positive findings

- Scandinavians in US (Ødegaard, 1932)
- Eastern Europeans to UK (Murphy 1972)
- Eastern Europeans to Australia (Krupinski & Stoller)
- Afro Caribbeans to UK (Eaton & Harrison 2000)
- West Africans to UK (van Os et al., 1996)
- Asians to UK (King, 1994)
- Surinamese, Antileans to NL (Selten et al., 2001)
- Moroccan men (Selten et al., 2001)

Negative findings

- Great Brittons to Australia (Krupinski & Stoller)
- Mexicans to USA (Robins & Regier, 1991)
- Turks to Germany (Weyerer & Häffner 1992)
- Turks to NL (Selten et al. 2001)
- Asians to UK (Bhugra et al. 1997)
- Moroccan women (Selten et al., 2001)

Hypothesis

A- the risk of psychosis is increased among first and second generation immigrants Morocco, Turkey, Surinam and Dutch antilles

B- In diagnosis by independent doctors there is less agreement about diagnose of immigrants in comparison with native patients.

Instruments:

- **CASH**: Comprehensive Assessment of Symptoms and History.
- **IRAO'S**: Instrument for retrospective Assessment of the onset of schizofrenia
- **BPRS**: The Brief Psychiatric Rating Scale
- Will be used to establish symptom profiles.
- **GAF-s & GAF-H**: Global assessment of functioning , symptoms and handicaps subscale will be scored to provide addition information on severity and social functioning.
- **CAN**: The Camberwell assessment of Need,
- and will provide information on pattern on need for care.

	population	Dutch native	immigrants	Maroccan
population Utrecht 2002	168322	116168	52154	12191
Utrecht expected psy.	?	25	?	14
Utrecht psy.	?	28	?	15

	Total	Schi.	Psychotic depresion	Depression without Psy.	Bipolaire Stoornis
CASH Maroccan	9	7 1(NAO)	1	0	0
CASH Dutch.	10	X	X	X	X
CASH (T) Maroccan	20	4 1(NAO)	10	3 2(X)	
CASH (T) Dutch	10	6	1	0	2

	CASH	CASH(T)	
8 Ned. Psy.	5 schizo. 2 bip. 1 psy. NAO	5 schizo. 2 bip. 1 psy. NAO	
8 Marok. Psy.	6 schizo. 1 dep. psy. 1 psy. NAO	2 schizo. 4 dep.psy. 1 psy.NAO 1 dep.	

- Tendencies toward misdiagnosis
- Increased psychosocial stressors
- Differential demographic characteristics of immigrant populations

- Hallucination and delusions are not always indicative of schizophrenia
- Misinterpretation of thought processes
- Fals negative symptoms

- Small numbers of cases
- Rate of misdiagnosis
- Illness behaviour

MENTAL HEALTH SERVICES FOR IMMIGRANTS IN DENMARK: PROBLEMS AND CHALLENGES

Marianne Kastrup

Centre for Transcultural Psychiatry
Rigshospitalet
2100 –Copenhagen, Denmark
Email: marianne.kastrup@rh.dk

1.INTRODUCTION:

At the 2001 Ministerial Round Table of the WHO 54th World Health Assembly Mr. Arne Rolighed the Danish Minister of Health at that time stated that in Denmark all persons have free and equitable access to the health system irrespective of sex, age, social status, and the problem from which they suffer. It was important for him to ensure that mentally ill patients were given appropriate treatment and to that end the Danish medical authorities work closely with research, education and quality assurance programs.
So far so good.

The ministerial comment clearly reflects the overall official approach to the availability of health care in Denmark including mental health care, namely that all residents have access to free care and that all receive equal treatment whether they are Danes or immigrants.

Since then Denmark has experienced a shift in government towards a liberal-conservative government with a particular focus on the welfare model and a shift in interest towards a privatization of services.
The government is also explicitly stating its concern for migration and its impact on the Danish society which I shall return to.

2. ORGANIZATION OF HEALTH SERVICES:

A few words about provision of health care in Denmark.
Health services are from an administrative point of view decentralized with the counties having regional health authority and providing the financial background for the provision of secondary health services including hospital care.

Primary health care is centered round the family doctor system. All residents in Denmark are entitled to a GP free of charge offering basic health care and having a function as the first filter and referral to secondary health care.

Psychiatric services:
Denmark has about 4.200 psychiatric beds (year 2000) and a further 1,300 day-patient facilities. The number of psychiatric beds has remained fairly constant over the last decade. At the same period the annual number of discharges has increased slightly but outpatient visits have decreased with 22 % as services have been reorganized towards community care.

Community mental health care is increasingly important, the number of services has increased from 80 in 1995 to 120 in 2000. Community services are available to all residents in Denmark. The activity has more than doubled over the period 1993-2000 and the number of patients in contact with community care has increased by 142%.

Contrary to general hospital services that are the responsibility of the regional health authorities of the country, psychiatric services are organized according to several models:

- Health model where all psychiatric care is part of the general health care of the region. (the Copenhagen model)
- Social model where community care is part of social services, but some inpatient care is part of general health services.
- A model where psychiatric care is organized in a separate authority including both inpatient and community care.
- A model where the community care is an organizational combination of social services and health services.

Inpatient services are usually organized according to catchment area so a specific service has total responsibility for all psychiatric care for that region. There is little emphasis on specialization of services but all departments will normally provide comprehensive services for all citizens of the region.

Following discharge from inpatient care patients with chronic or severe psychotic disorders will typically be referred to continued care at a community psychiatric facility. Here it may frequently be necessary to combine the health activities with social psychiatric services.

It is outlined in the Danish Mental Health Act that a treatment plan and a social action plan should be available and agreed upon with the patient.

Social psychiatric services:
These services are part of social services and usually without medical supervision. They may include Fountain house activities, workshops, housing arrangements, sheltered work, vocational training. The level and extent of activities varies substantially by region and the coordination with health services will usually be minimal.

3. DEMOGRAPHY IF IMMIGRANTS:

At January 1, 2001 Denmark had 396,000 immigrants that is 7.4 % of the population. The large immigrant groups were:

From other EU countries: 18.7 %

From Europe outside EU: 35.7% out of which were the:
Turkish: 12.7%
Yugoslavs: 10.4%

From Africa: 9.7% Out of which
Somalis: 4.0%

From North America: 2%

From Asia: 31.3% out of which were:
Lebanon: 5.0%
Pakistan: 4.6%
Iraq: 4.6%
Iran: 3.4%
Vietnam: 2.9%

From these statistics it appears that from a transcultural point of view the groups of particular concern are:
The Turkish population
The Ex-Yugoslavs
The Middle-Eastern population, including Pakistan.

The delineation of the immigrant population is far from easy as there is no natural way to distinguish patient populations who fall under the category "transcultural."

Immigrant status in Denmark:
Looking at the reasons for coming to Denmark:

The permits granted for 2001 (38,591) were distributed as:
Asylum: 16.2% (6,263)
Family reunification: 34.2% (13,187)
Other residence permits, e.g. work, education, au pairs, adoption: 34.2% (13,191)
EC/EEA residence certificate: 15.4% (5,950)

4. SERVICES FOR IMMIGRANTS:

Despite the fact that Denmark is experiencing an increasing number of immigrants as psychiatric patients, little focus has been directed towards investigating their special needs and demands with respect to health.

Till now we have no very accurate figures about the size of the immigrant psychiatric population. Estimates given focus on approx. 10-15 % of inpatients at any given time have a non-Danish background.
In some areas about 25% of the patient population has a non-Danish background and if we consider the forensic psychiatric services it is found that foreigners comprise 30-40% of the patients in some wards and in the special services for the very dangerous psychiatric forensic patients the percentage amounts to 50.

There is no explicit mental health policy directed towards immigrants and no special services provided. This is however not surprising taking into account the way psychiatric services are structured with little specialization if any.

From an organizational point of view, assessment and treatment of psychiatric disorder among immigrants depend upon the immigrant status of the person:

Refugees:
Asylum seekers:
The responsibility of health care of asylum seekers has been delegated to the Danish Red Cross that is responsible for providing health services - including mental health care - to asylum seekers and refer them to specialist care when found appropriate.

When asylum seekers arrive to the reception center in Denmark a health check is carried out by a nurse. Is a torture trauma suspected, a medical examination takes place and the person may be further referred to psychological/psychiatric treatment.

Any person who is diagnosed in acute need for psychiatric treatment will be referred to the regional psychiatric facility.

Integration phase:
Having obtained asylum, the person gets access to the Danish health care system which means that he/she is allotted a GP who is the first contact person in health matter and filters to secondary care.

Services that are part of the public system are accessible free of charge.

A variety of different specialized services are established with a focus on traumatized refugees - some on county level other on municipal level.
Some services for traumatized refugees are part of the public health system at county level, e.g. a specialized team for traumatized refugees as part of the mental health services.
Some services are established outside the health services but within the public system, e.g. the social system and focus on psychosocial treatment of traumatized refugees.
Some services may be established at municipal level as specialized services for traumatized refugees.

Finally, a number of private organizations have emerged to help traumatized persons offering primarily psychosocial rehabilitation. Refugees referred to these organizations will usually apply to the local social services for economic support and the social services may agree to pay for a specific number of consultations.

Immigrants that are Non-refugees:
Immigrants that come to Denmark as non-refugees and have a permit of residency are after a 6 weeks period entitled to the public health services.

This means that they have access to the same services as the Danish population free of charge.

Others:
Foreigners who temporarily visit Denmark but have no residency may receive health care in case of acute illness but are not entitled to long-term treatment.

5. SURVEY OF PROJECTS AND SERVICES:

No systematic information about services and projects directed towards immigrants exist in Denmark. As a part of the work of the Transcultural Centre a survey has been carried out May 2002 in which a questionnaire was sent to all regional psychiatric authorities, all psychiatric departments

and community mental health services requesting information about services directed towards immigrants, projects involving immigrants, educational programs, etc. Further all departments were requested to appoint a contact person serving as a liaison officer between the department and the Transcultural Centre.

Following this survey and based upon the information received, four regional network meetings have been carried out in October 2002 involving the regional contact persons. The strategy to travel to the different regions of the country was chosen in order to facilitate a regional feeling of ownership towards the project. The regional meetings have had the form of group interviews in which the participants have received the questions prior to the meeting.

Questions focused on :
Communication
- language barriers
- demands to the interpreter

Training
- the influence of staff attitudes to the clinical work
- the role of and need for supervision
- perception of disease and health by staff
- role of religion and culture in relation to rituals

Therapeutic aspects
- Key problems encountered at local level by psychiatric staff
- the therapeutic milieu at the wards and its adaptation to other cultures
- initiatives to improve quality of treatment and care
- major challenges in the work with transcultural patients
- distinction between what is culture and what psychopathology
- in what way does culture influence treatment provided
- work with the transcultural family
- initiatives to improve diagnostic and treatment

Organization
- collaboration between disciplines both within and between services
- expectations towards the Transcultural Centre

The nationwide survey showed that a number of initiatives have emerged across the country but till now with little systematization. Many small projects may have materialized thanks to a few interested individuals and have received little attention outside the local setting. Here an important task will be to assemble these experiences and to ensure a cross fertilization across the country, but also to initiate a more systematic evaluation and follow up of such initiatives.

Among the initiatives could be mentioned :
- the use of regular consultations to Danish staff by an ethnic therapist
- interdisciplinary working groups on how to improve therapeutic offers to ethnic patients, and strategies to improve quality of treatment and care
- educational activities on many levels and quantities involving psychiatric staff as well as adjacent groups

- collaboration with anthropologists to describe mechanisms and interpersonal relations between staff and patients in the therapeutic setting
- appointment of a resource/contact person or teams who serve as consultant and coordinator of the transcultural work,
- introduction of regular formalized collaboration between primary and secondary health services and social services
- activation of mentally ill refugees

6. INTEGRATION OF MIGRANTS ISSUES OF CONCERN:

Population:
Mentally ill immigrants comprise a multifaceted group that may have very different needs and problems.

Ethnic minorities are often considered as one large fairly uniform group despite the fact that Denmark has a number of very different ethnic groups. Further ethnic patients are as different as Danish patients with respect to social background and there is among the Danish population frequently a tendency to consider immigrants as relatively uneducated in stead of seeing their diversity.

Little information is available at present about the size of the problem, the socio-demographic profile of the population, its geographic distribution and utilization of services.
Neither are the needs of the group of immigrants elucidated. The tendency has been to pay particular attention to certain groups, e.g. the group of refugees and particularly the traumatized refugees.

Services:
It is characteristic that certain groups, in particular among refugees, exhibit a complexity of problems requiring the attention and intervention of a series of agencies: physical and psychological problems, family problems, social problems related to housing, language, education, work, contact with schools due to problems with children, legal problems and discrimination.

Contrary to Danish citizens, immigrants have difficulty in manoeuvring among the compartmentalized and rather complex types of public services and may bring the "wrong" kind of problems to a given service, e.g. using emergency services to non-acute problems that should be handled by GPs.

Services may not be adequate to cover the needs of immigrants – some groups may feel pushed from one agency to another with insufficient collaboration between agencies resulting in that the immigrant so to speak "falls between chairs".
Others may experience that a given service is geared for the Danish population and less for immigrants resulting in that the immigrant may "fall through the chair"

Immigrants that are not refugees are expected to use the health care system including the mental health care system just as the Danish population. This may sound easy but little introduction to or information about the system is available, e.g. in the forms of folders in different languages.

Staff:
Treatment and care of mentally ill immigrants is a challenge and requires a enhancement of the cultural competence of the staff and a special effort with due consideration of the personal and cultural background of the patient.

Staff needs to be trained in the adequate use of interpreters.

Training in specific topics related to the diagnostics treatment and care of the immigrant patient.

Ethnic patients are often seen as difficult to deal with and are described as “heavy”, and therapists may tend to focus too much on the culture as a way of explaining behavior and symptomatology thereby letting the culture become an obstacle rather than a resource.

7. FACTS:

We know today that:
Refugees are frequently severely traumatized and have a high prevalence of PTSD
PTSD has a high co-morbidity with depression and anxiety disorders
Lack of social network increases the psychiatric morbidity risk
Severe language barriers often hamper the therapeutic interventions with immigrants
Interpreters with knowledge on psycho-social matters are rare and not always available.
Mentally ill immigrants often exhibit a great complexity of problems involving a multitude of agencies.
Work with ethnic minorities is often time consuming and sufficient time and resources should be allocated.

8.RECOMMENDATIONS:

Organization

We have to recognize the complexity of the problems presented by the immigrant population.

The strict boundaries between general psychiatric care and care for traumatized refugees are not beneficial and initiatives should be taken to bridge the gap.

Availability of information folders etc in all relevant languages

The physical facilities of the mental health services should be adapted to satisfy the needs of immigrant patients.

Accreditation standards for good practice in assessment and care of transcultural patients.

Qualified interpreters with knowledge on psychiatric/psychological terminology should be available whenever required.

Range of activities available comparable for native and immigrant populations.

Treatment
Treatment of mentally ill immigrants should focus on community mental health care with a possibility to involve experts on cultural matters.

Treatment requires a multidisciplinary approach with due consideration to psychological/psychiatric problems but also to physical, social, spiritual and legal.

Empowerment aspects should be an integrated part of all treatment.

We have to strike the right balance between over interpretation of the cultural influence and lacking cultural sensitivity.

Need for adequate introduction to local hospital routines

Establishment of group support for relatives

Training
Training on cultural matters and understanding as well as more specific knowledge on transcultural matters should be part of the curricula of the psychiatric professions.

Special programs should be established to increase the cultural competence of the psychiatric staff.

Strengthen cultural sensitivity and awareness of cultural values among mental health professionals

Training in the use of interpreters

Supervision of clinical staff is needed on the complex transcultural cases.

9. CONCLUSIONS

The particular problems related to the treatment of immigrants with mental disorders is still a relatively new field in Denmark. Several initiatives are presently materializing and the development is ongoing.

There are many obstacles to treatment. As therapists we have to recognize :
That it is necessary to pay particular attention to reach equity in the provision of services and
That resources are needed to cover these needs.

It is of crucial importance to establish networks across disciplines and across countries if we are to have an impact on the organization of care and ultimately the quality of treatment offered to this population.

Living in a world of increasing globalization and in recognition of that Europe is a multicultural region this issue needs to be put on the agenda of health politicians and a meeting like this one represents an important step in the right direction. .

MEASUREMENTS OF SATISFACTION FROM A TRANSCULTURAL PSYCHIATRY OUTPATIENT UNIT

F.Gonidakis
K.Kattan
A.Takad
D.Ploubidis
G.N.Christodoulou

Athens University, Medical School, Psychiatric Department,
Transcultural Psychiatry Outpatient Unit

Eginition Hospital Psychiatric Clinic
Vas. Sofias 74 av 115 28
Athens
Greece
Tel: 00306977370056
Email: fragoni@yahoo.com

INTRODUCTION

During the last ten years over a million immigrants have arrived in Greece (a country with a population of 10 millions). More than half of them have settled in Greece while the rest tried and succeeded in leaving for other European countries or North America.

The immigrants that decided to settle in Greece usually worked at manual labour jobs not only for less money than their Greek colleagues but also without health insurance. Sometimes housekeepers from Eastern Europe and the Balkans were obliged to work for six days a week without being able to leave the house even for a visit to their doctor. Although the new legislations on immigration tried to prevent this form of exploitation there is still a high percentage of immigrants that for various reasons live and work in Greece illegally.

Keeping in mind the previously described situation it is understandably why most immigrants seek medical help from public hospitals and not from private services or doctors. Of course the above apply also for those patients that are suffering from a mental disorder.

When the number of immigrants increased dramatically the state psychiatric services and specifically the emergency rooms were quite frustrated as they had to deal with patients coming from different countries, with a poor knowledge of Greek or any other western European language, presenting with symptoms that they psychiatrist have not faced again or could not diagnose easily.

Also the lack of health insurance most of the times left the psychiatrist no other choice but to prescribe older and thus cheaper medicines. This type of medicines would probable cause more side effects (mainly in the case of antipsychotics) and thus raised the possibility that the patient would not be able to work. Of course if the patient did not work it would be extremely difficult for him/her to be granted permission (this does not apply to asylum seekers) to stay in Greece so the patient would probably keep on being illegal and uninsured.

The only temporally solution to the above was the collaboration of the psychiatric services with medical NGO's like Doctors without Borders (MSF) and Doctors of the World (MDM) who could provide (unfortunately for a limited number of patients due to low supplies) the medicine that the psychiatrist had prescribed. Sometimes though when the NGO could not provide the prescribed medication then the collaboration collapsed, as the patient did not returned to the psychiatrist to get another prescription for a cheaper medicine. He/she would just remain untreated, certain that the Greek medical system could or even worse did not wanted to help him/her.

The above escalating situation led the Psychiatry Department of Athens University Medical School to the decision to establish a transcultural psychiatry (TP) unit that would address more efficiently the above issues.

It main goal was to provide a more culturally sensitive service to the population of immigrants that were suffering from a psychiatric disorder, to establish a more firm alliance with other non psychiatric services that were focusing on immigrants and finally to provide training to other psychiatrists on transcultural issues.

AIM

The main aim of our study was to measure the quality of the services that are provided to the TP unit. It was always a strong believe of ours that patients are the best judges of the quality of our work as they are the main receivers of our efforts. The above was the reason why we chose to use them as evaluators of our service

METHOD

20 patients that have been treated for more than a year on a regular basis have been asked to fill in the Verona Service Satisfaction Scale (VSSS-EU). The Greek edition of VSSS-EU is currently under validation so our results are presented with some reservations concerning the validity of the scale. The VSSS-EU includes a broad spectrum of items that evaluate the whole aspect of psychiatric services so the ones that were irrelevant to our service (like rehabilitation activities, inpatient treatment, opinion on other than psychiatrist mental health specialists etc) were omitted. For each question there were five available answers ranging from 1=bad to 5=excellent. The administration of the scale was carried out by a member of our staff that was not involved in the treatment of the specific patients~

RESULTS

We distributed the answers to the items of the scale into four major groups

a) Satisfaction from the treatment and the psychiatrist

There were 14 questions on the treatment effectiveness, the attitude and the efficiency of the psychiatrist and also on the support he offered to the patient and the family. Results are presented in table 1. Most of the patients rated as satisfactory both the individual treatment and the family/relative interventions

b) Satisfaction from the non medical personnel

There was only one question referring to the attitude of the non-medical personnel of the outpatient clinic. The results are presented in table 2. More than half of the patients rated the attitude of the non-medical personnel as satisfactory

c) Satisfaction from the facilities of the hospital

There were two questions on the hospital's facilities, one concerning the waiting room and the examination office and the other the cost of the treatment (the appointments with the psychiatrist are without charge). The results are presented in table 3
Most of the patients rated as satisfactory the waiting room and examination office and as excellent the cost of the treatment

d) Satisfaction from the TP outpatient unit's function

There were 25 questions for the evaluation of the TP outpatient unit's efficiency (treatment, rehabilitation, response to crisis and emergencies) provided psychosocial support, punctuality, confidentiality and information. The results are presented in tables 4a&b

Most of the patients rated as satisfactory the confidentiality, efficiency and punctuality of the unit, their opinions were split on the level of information they had for the unit before the first appointment and also for the disorder they were facing. Also their opinions were split considering the support they had from the unit in order to participate in outdoor recreational activities. Most of the patients would not like to stay in a psychiatric shelter, to be hospitalised or to participate in group psychotherapy. They would very much like to be helped to find protected or non-protected jobs or to receive welfare benefits. They would also like to have house calls by members of the therapeutic team

DISCUSSION

Although the overall impression of our patients for our unit was quite satisfactory more steps have to be taken to make this unit more widely known not only to the public but also to services that provide support to immigrants and refugees.
An improvement of the social support offered by our service especially in the areas of employment and welfare would be more than welcomed by our patients. This can be achieved by a more firm collaboration either with the hospital social service or with non-medical NGO's that provide this type of services to immigrants and refugees.
As for the evaluation the presented results are a part of an ongoing procedure. A comparison with the results from a general psychiatry outpatient clinic of the same hospital is currently in the stage of statistical analysis.

TABLES

TABLE 1

	The psychiatrist and the patient	**The Psychiatrist and the family**
Bad	**0%**	**0%**
Not satisfactory	**0%**	**0%**
Mixed	**3,9%**	**10%**
Satisfactory	**58,3%**	**80%**
Excellent	**37,8%**	**10%**

TABLE 2

Attitude of the non Medical Personnel	%
Bad	0
Not satisfactory	14,3
Mixed	28,6
Satisfactory	57,1
Excellent	0

TABLE 3

	Waiting room and office	Financial burden
Bad	0%	0%
Not satisfactory	0%	0%
Mixed	14,3%	0%
Satisfactory	71,4%	42,9%
Excellent	14,3%	57,1%

TABLE 4A

	confidentiality	punctuality	efficiency	information	Psychosocial support for recreation activities
Bad	**0%**	**0%**	**5,9%**	**14,3%**	**0%**
Not satisfactory	**0%**	**0%**	**0%**	**14,3%**	**0%**
Mixed	**14,3%**	**0%**	**20,3**	**21,5%**	**50%**
Satisfactory	**71,4%**	**57,1%**	**48%**	**28,6%**	**0%**
Excellent	**14,3%**	**42,9%**	**25,8%**	**21,3%**	**50%**

TABLE 4B

Psychosocial support	shelter	Group therapy	Protected Job	Inpatient treatment	House calls	Welfare Benefits	Non protected job
Yes	**16,7%**	**28,6%**	**100%**	**14,3%**	**57,1%**	**85,7%**	**80%**
Not know	**0%**	**14,3%**	**0%**	**14,3%**	**0%**	**0%**	**0%**
no	**83,3%**	**57,1%**	**0%**	**71,4%**	**42,9%**	**14,3%**	**20%**

THE PROVISION OF CULTURALLY APPROPRIATE SERVICES IN A MULTI-ETHNIC COMMUNITY FOR PATIENTS SUFFERING PTSD- A REPORT FROM EAST LONDON

Patricia d'Ardenne
N. Capuzzo
W. Fakhoury
S. Priebe

Institute of Psychotrauma
Barts and the London School of Medicine and Dentistry
West Smithfield
London, EC1A 7BE
United Kingdom
Email: patricia.dardenne@elcmht.nhs.uk

ABSTRACT

The Eastern Boroughs of London are among the most culturally diverse in Western Europe, with over 40% of the population of 700,000 from minority ethnic communities, that is ever changing. They contain a significant number of asylum seekers from global and regional conflicts. The area is characterised by religious and cultural diversity, by economic and social privation, by a burgeoning young population.

This paper seeks to define in what way diversity impacts on the symptoms of patients suffering the effects of life-threatening events. Data will be shown that the subjective quality of life (SQOL) of patients with PTSD is even lower than that of patients with schizophrenia, depression, or alcohol addiction. Further, depression, anxiety, increasing age, and being of any minority ethnic group predicts lower SQOL in patients with PTSD. This effect is not specific to any one culture. Rather, any individual from outside the dominant culture, who may experience economic and social privation, racism and alienation, is more likely to have lower SQOL. The effectiveness of a specialist East London team- the Institute of Psychotrauma- in reducing PTSD symptoms and at the same time increasing SQOL is described. The Institute supports patients from very different backgrounds in assessment and treatment, and makes general recommendations to community mental health teams on managing PTSD patients after discharge. Specific attention is given to how the Institute uses local resources, interpreting services and the communities themselves to achieve improvements, regardless of the specific culture of the patient.

The Eastern Boroughs of London provide us with a microcosm of the world, its transitions and its mental health problems. Some Borough wards are 99% minority ethnic e.g. the Bangladeshi community of Tower Hamlets. Hackney and Newham have over 40% of the population of 700,000 from over 50 minority ethnic communities, that is ever-changing, and which contain a significant number of asylum seekers from global and regional conflicts.

The area is characterised by religious, social and cultural diversity, by poverty, and by an increasingly young cohort of the population who seek education, healthcare, housing and employment in a country that they perceive as asylum. The Institute is based adjacent to East London, at St. Bartholomew's in the City of London – one of the richest money markets in the world- where a third of the world's wealth can be exchanged electronically in a single day's

trading. Sociologists call extreme wealth and poverty sitting cheek by jowl economic propinquity (Urry, 2003).

There remains a fundamental debate in mental healthcare about the need for specivity or sensitivity to diversity, (Bhui and Sashidharan, 2003; Bhui and Olajide 1999). The debate can be briefly described as follows.

Research has already demonstrated racial, ethnic and cultural inequalities of access to specialist psychiatric care, as well as differences in the assessment and management of people from minority groups. Since every member of the community is entitled to equal access to health, only ***specialist*** services – previously organised by the voluntary sector, are likely to have the political will, and the sensitivity to the need of users to be of any value in addressing the health imbalance, and the institutionalised racism in psychiatry, psychology and other health professions. Individual health workers may not be racist, but the practices, perceptions and indifference to diversity creates a culture of dissatisfaction, higher rates of black men admitted to inpatient and forensic care, and a dearth of research into ethnicity and mental health.

The counter argument is that cultural diversity has always needed to be understood and planned for in mental health. It must be mainstream psychiatry that takes responsibility for ensuring its workforce and its practices are ***sensitive*** to difference and value it. Specialist, separate development, however, lets the dominant culture, and Western psychiatry in particular, 'off the hook' in its responsibilities to a wider community. It places culture or race above all other considerations of difference, and pathologises its role in the genesis of psychiatric disorder.

The debate continues. In East London there remain practical reasons for a non-specific, culturally sensitive approach to mental health problems, and especially for the needs of refugees and asylum seekers suffering with post-traumatic stress disorder. Referrals have come from over 27 different countries in the past 3 years; the Institute has hired interpreters from 18 languages in that time. Even if ethnic matching of therapist to client were appropriate, it would be impossible, as there are rarely more than four members of staff available at the institute. Therefore, a more pragmatic model of working transculturally has evolved.

The East London and City Mental Health NHS Trust staff profile has undergone significant changes in the few years ethnicity has been monitored. 40% are white UK; 40% are black, and 20% are other nationalities. This profile is not a mirror of the communities of East London- the Bangladeshi community of Tower Hamlets is barely registered; nor does it show the distribution of ethnic minorities in senior medical or managerial posts. But it represents a major shift in employment practice and organisational and cultural changes

The Institute of Psychotrauma is a small specialist service with four part-time clinicians and their trainees. Since 2001, the Institute has received 150 referrals per year or assessment or treatment. The service endeavours to assess the psychiatric and psychological symptoms of patients who are referred from their local community mental health teams. If treatment is appropriate, patients are offered a brief intervention of approximately 8 sessions of CBT to help them revisit their traumatic memories and/or to help them restructure their constructs around those historical events (Foa et al., 1991; Marks et al 1996). There is sufficient evidence that exposure, cognitive restructuring or a combination of the two is superior to any counselling or relaxation training. Van de Veer (1998) has described how Western CBT models can be well adapted to the needs of refugees in Western clinical settings- albeit with some reservations.

As part of pre-treatment assessment, the Manchester Quality of Life Scale (MANSA) is administered. The MANSA is a reliable and valid tool for evaluating subjective quality of life in 8 major domains. SQOL is an important characteristic of mental well-being, that embraces a biopsychosocial model of service provision (Priebe,1999; Priebe et al 1999). The data on the first 90 patients to complete their assessments were then compared with other psychiatric groups and with healthy controls. These groups included 42 depressed women, 70 alcoholic women, 90 outpatients with a diagnosis of schizophrenia, and 207 medical students.

The results of this initial analysis show that in practically all domains, the PTSD patients reported lower SQOL than anybody else. The only exception was that inpatient women with depression reported poorer satisfaction with their mental health than our patients. In every other respect, the study group displayed *remarkably* low SQOL, and their total satisfaction with life in general scores are lower than any of the psychiatric controls. It is known that the profile of patients in this clinic is heavily biased towards survivors of torture and the atrocities of war. Many are seeking asylum in the UK.

They were most frequently male, young (X= 37 years) with two thirds from a minority ethnic group, and more than a third living alone and unsupported. Most were unemployed, and in receipt of state benefits, and almost a third were seeking asylum in the UK from zones of conflict. 27% had direct experience of or had witnessed the atrocities of war; 22.2% had been the victims of torture; 32.5% had been the victims of crime, and 17.5% had been the victims of accidents. 33% required the use of an interpreter and a further 33% did not speak English as their first language. The DNA (Did Not Attend) level of our clinic is the same as that of other mental health services. A recent audit of showed that patients who are English-speaking have *higher* rates of DNA ($p<.001$) than those who require interpreters. (Table 3).

TABLE 3 AN AUDIT OF ENGLISH-SPEAKING AND INTERPRETED PATIENTS IN THE TRAUMA SERVICE 2001-2003

Number of patients audited N= 324	English Speaking N=160	Interpreted Patients N=164
Total number of missed sessions	158	98
Mean number of DNA's	1.09	1.01 $p<0.01$
Lost Interpreter Sessions (cost)	-	£5,047

Does social or ethnic status **predict** low SQOL in this study group?

Depression, as measured by the Beck Depression Inventory, was the biggest factor in predicting low SQOL. Ethnicity i.e. being non-white UK, being older and experiencing violence in the past year accounted for 39% of this. This effect, however, is *not* specific to any one culture. Rather, any individual from outside the dominant culture, who is more likely to experience economic and social privation, racism and exclusion, appears also more likely to have lower SQOL. Our pre-treatment assessment shows that those who have been socially marginalized by culture, life

experience or age are also those who experience progressively lower overall SQOL in all domains.

For example, ethnicity and language support requirements are identified before a referral is accepted, and as much biographical and trauma history from the referrer as possible is obtained. This may include reports from specialist services such as the Medical Foundation for the Care of Victims of Torture, or Legal depositions to the Home Office (Ministry of Internal Affairs), about the circumstances leading up to their obtaining indefinite leave to remain in the UK. This is to improve selection of cases, and ensure that other relevant agencies that should be involved with the case are already doing so. In East London, there exist many organisations concerned with the supporting, informing and liasing with different communities- often on a voluntary or charitable basis. The patient is then sent information about the Service – wherever possible in his or her own language. The most common ones at the time of writing are Turkish, Albanian, Arabic, Somali, French, and Swahili and Lingola.

Clinicians at the Institute do not represent the wider ethnic profile; but they do have other cultural origins, and cultural competencies that emerge from that. For example, colleagues who have lived overseas are more aware of alienation. Anyone who has learnt a second language will understand the concept of linguistic equivalence, and the difficulties facing interpreters and translators in mental health assessments and treatments (d'Ardenne and Mahtani 1999). The Institute staff are trained to use interpreters or preferred advocate, are therefore always able to speak with patients in the second person. Relatives will also be seen, both with and without the patient, as appropriate. Occasionally patients request that a relative come as an interpreter, which is not welcomed. Patients are advised about confidentiality and power, and this is explained to any member of the family who may be present in the waiting room.

The Hackney Interpreting Service provides interpreters who are vetted, and professionally trained. Care is taken to ensure that gender, ethnicity and anonymity as well as language are taken into account, wherever possible. For example, a Turkish speaking Kurdish survivor of torture in a Turkish prison is unlikely to work with an ethnic Turk. Female rape victims who experience extreme shame will not talk in the presence of a male interpreter, and are more likely to be allocated a female clinician.

Occasionally the interpreting service may not have a rare language, or a patient turns up in an emergency, where no interpreter has been booked. In this situation, we book LanguageLine a 24-hour telephone interpreting service that can access up to a hundred languages within 100 seconds of contact. Although this service is costly, it has the double advantage of great flexibility, and anonymity since the interpreter is connected to clinician and patient only by a double telephone.

Other cross-cultural skills are deployed in our practice. Printed or electronic atlases are opened to locate a patient's birthplace and/or the location of their traumatic experiences. We may use the Net to locate BBC World Service regional news or other websites that provide information about a patient's own community. Patients may also be encouraged to locate services e.g. the International Red Cross to address pressing concerns about the whereabouts of families or loved ones.

The Institute is a clinical and research establishment that aims to reduce PTSD symptoms, improve mood, and tackle the very low levels of SQOL in our patients from many backgrounds. Our initial post-treatment findings suggest that patients' PTSD symptoms can be ameliorated, as

measured by the IES_R and the CAPS, and that depression and anxiety can be significantly improved, although the problem of low SQOL remains. Early post-treatment comparisons have revealed that SQOL continues to remain low- although mood and IES_R scores all improve. In some comparisons SQOL actually deteriorates, as the patient increases insight and expectation of a better life- only to be confronted with a reality that doers not reflect this.

This finding regularly features in the reports and discharge plans made by the Institute when individual patients are returned to their CMHT's. Our reports place heavy emphasis on social inclusion, daytime activity, family and friendship networks, learning to speak English, and obtaining civil status as essential concomitants of effective psychotherapeutic outcome.

Many of the assessments, however, do not lead to treatment. Patients are too distressed, too impoverished or too overwhelmed by social, medical and legal concerns to be available for psychological treatment. Low mood is determined not just by traumatic events, but also by dissatisfaction with family, friends, employment possibilities, finances, mental health, and life in general. East London has a wealth of Community groups, organisations, churches, mosques, political and cultural movements, as well as excellent interpreting and advocacy services within statutory social, housing ands services. The assessments, formulations and recommendations extend beyond the purely psychotherapeutic, and reach to the cultural and political contexts in which many of our patients find themselves.

Clinical practice continues to evolve, and place great demands not just on the patients, but also on the clinicians, none of whom works full-time in trauma. Research in this field is even more challenging. Patients are fearful, and reluctant to give information. The reliability of data is affected by the motivation of patients, the skill of interpreters, and the persistence of the researchers. In conclusion there are no ideal solutions to these complex issues which we face, and which you might be facing now or certainly in years to come. The preferred model is consistent, culturally sensitive but not culturally specific. It permits cross-cultural competencies in both the clinician and the patient, and remains flexible to the local and global changes that impinge on East London.

REFERENCES

Bhui K and Sashidharan S, (2003) Should there be separate psychiatric services for ethnic minority groups? *British Journal of Psychiatry*. Vol 182 January, pp10-12

Bhui, K & Olajide D (eds) (1999) *Mental Health Service provision for a Multicultural Society.* London. W.B. Saunders.

d'Ardenne P and Mahtani (1999) *Transcultural Counselling in Action* Sage Publications. London.

Foa E.B., Steketee, G. and Rothbaum, B.O., (1989) Behavioral/cognitive conceptualisation of post-traumatic stress disorder. *Behavior Therapy,* **20,** 155-176

Marks I., Lovell, K., Noshivarni, H., Livanou, M., & Thrasher, S. (1988) Treatment of post-traumatic stress disorder by exposure and/or cognition restructuring. *Archives of General* Psychiatry., **55,** 317-325

Priebe S., (1999) Applications and Results of the Manchester Short Assessment of Quality of Life (MANSA), *International journal of Social* Psychiatry, 45, 7-12

Priebe S., Oliver J., and Kaiser P.,(Eds.1999) *Quality of Life and Mental Health Care*. Petersfield. Wrightson Biomedical.

Urry J. (2003) *The Global Media and Cosmopolitanism* Department of Sociology, The University of Lancaster.

Van de Veer G (1998) Chapter 4 pp 76-84, Working with Cultural Differences, in *Counselling and Therapy with Refugees and Victims of Trauma* Second Edition. Chichester. John Wiley and Sons

USEFUL WEBSITES

www.cbc.ca/news/indepth
www.amnesty.org.uk
www.bbc.co.uk
info@mind.org.uk
www.ifrc.org
www.kosovo.uk
www.refugecouncil.org.uk
www.nato.int
www.torture.org.uk

MIGRANT HEALTH ISSUES AS INTERPRETED IN MODERN ENGLISH LITERATURE

Maurice Cauchi

University of Malta
Department of Pathology
Medical School
St Luke's Hospital
Guardamangia, Malta
E-mail: maurice.cauchi@um.edu.mt

ABSTRACT

Health issues, including mental health problems, feature prominently in the analysis of migrant issues. The reasons for these are varied, but include both the personality make up of the individual, the mental stress involved in the process of separation and settlement, as well as the environmental factors faced by migrants at home and at work. Migrants are often ill-prepared to deal with the new challenges that they meet in their new home. They react to these situations in different ways. Many make the necessary adjustments, but others find it very difficult to compromise, with the result that long term health problems eventually become evident. The list of psycho-somatic disorders is a long one, and it is suggested that neither the migrant, nor the health professional is adequately attuned to recognizing the relevant symptoms. The need for providing ethnic-specific health services has been a long-felt one. It is often very difficult for a health professional to fully appreciate the root of the psychological problem if one is not aware of the background, tradition and mores of their client. The approach taken in this paper is to see these issues from the perspective of English literature writers in the last half-century. These authors, often migrants themselves, or first generation descendants of migrants are in a position to paint a vivid picture of life in a new land with all its warts and roses.

1. INTRODUCTION

A review of English literature over the past half-century reveals a considerable pre-occupation with issues relating to migrants. This results from an upsurge in the number of writers who have been part of, or influenced by the migrant experience. Writers like Salman Rushdie, V.S.Naupaul, Eva Hoffman, Nirad Chaudhuri, Ruth P.Jhabvala, Bernard Malamud, Edward Said, to mention just a few writers, have managed to turn our collective attention to a very significant social issue portraying the vicissitudes that migrants have to experience in their quest of finding a new home.

In my recent book *Worlds Apart*[1] I analyse the various aspects under a number of headings, including: Leaving, Arrival, Settlement Process, Identity, Language, Isolation, Rejection, Returning, The Second generation, etc. I believe that health issues are involved in all of these aspects.

I need not emphasize the fact that the average migrant (and here we may include the asylum seeker also) is often poorly prepared for the dramatic events that often characterise the transition from homeland to new land. They often do not posses more than the most basic level of literacy

[1] M. N. Cauchi: *Worlds Apart.* Europe-Australia Institute, Melbourne, 2002.

and educational standards which makes all levels of communication, but particularly communicating medical problems (and psychiatric problems in particular) very difficult.. They may be afflicted by levels of poverty which make it difficult, at least initially, to make both ends meet. They often have to work long hours at lowly paid jobs, often involving those jobs not wanted by the well-established members of the community. Some, particularly women caring for children as well as the elderly, are exposed to long periods of isolation which tend to compound these issues. These factors combine to make migration a risky business from the health point of view.

What I intend to do in this paper is to reflect briefly on some health-related outcomes in migrants as reflected in the literature. I chose this method in writing my book primarily because I believe that literature can express far more deeply and intensely than any textbook the issues and emotions involved in the process of migration.

2. LEAVING

Even as soon as a person makes up his or her mind to migrate, one may be assailed with health issues. The qualifying medical examination used to be a considerable hurdle in the times when diseases like trachoma or tuberculosis used to be major health problems, and this could be seen as a stigmatising procedure dividing the desirable healthy prospective migrants from those who are rejected and have to stay put.

The mental strain put on members of the family by the process of separation cannot be under-estimated because, as has been said, the 'possibility of migration represents a threat of disintegration'[2]. Migrants cut off their source of mutual sustenance. Those that are left may be afflicted by feelings of blame because they may think that that perhaps they could have done something to prevent the separation, and this may culminate in depressive episodes. They may feel angry, betrayed, annoyed. They may develop paranoid feelings. Hypochondriacal reactions may lead to psychosomatic disorders, including even heart attacks. A character in George Lamming's novel *In the Castle of my Skin*[3] says: 'The earth where I walked was a marvel of blackness and I knew in a sense more deep than simple departure I had said farewell to the land'.

It has also been argued that migrants are a self-selected group. Grinberg and Grinberg[4] argue that people with schizoid tendencies tend to make rush decisions to migrate, partly because they have difficulties in making lasting relationships. These are also the group most likely to return back to the mother country because of the difficulties they find in striking new roots.

Vitali Vitaliev, a Russian émigré to Australia remarks: 'The end of any life is death… emigration is still a rehearsal of one's own funeral.'[5] In fact, the literature abounds in examples where migration is portrayed as a process of dying, of passing away to another world. This concept is very prominent in African myths where we find the metaphor of death described as a state of migrancy. 'There are those who believe that to die is only to change places on this earth. The deceased continues in existence in another country or region far away from his former home.'[6] In this way the grief involved in the process of dying is attenuated somewhat. Amos Tutola [7] writes: '… I thought within myself that old people were saying that the whole people who had died in this world, did not go to heaven directly, but they were living in one place somewhere in this world.'

---

[2] L. Grinberg & R. Grinberg, *Psychoanalytic Perspectives* in *Migration and Exile.* Yale. U.P.1989, p 39.
[3] G. Lamming, *In the Castle of my Skin*, Michael Joseph, London, 1960, p 303.
[4] L. Grinberg & R. Grinberg , *op.cit.* p 156.
[5] V.Vitaliev, *Vitali'Australia.* Random House, Milsons Point, 1991. p 209.
[6] See: B. King, (Ed.), *Introduction to Nigerian Literature,* Universityh of Lagos & Evans Brothers,1 971, p 67
[7] A. Tutola, *The Palm Wine Drinker* Faber, London, 1952, p 9.

Part of the myth of long-distance travel, whether it is to the next world or to another far-away country, has involved arming oneself with food, trinkets, belongings, and other paraphernalia which might be of use on the journey. The modern migrant, no less than the Egyptian mummy, felt more secure and confident when surrounded by these objects. The Trinidadian born writer V.S. Naipaul, describing Indian emigrants to Trinidad, put is as follows: 'Yet so many left, taking everything – beds, brass vessels, musical instruments, images, holy books, sandalwood sticks, astrological almanacs. It was less an uprooting than it appears. They were taking India with them.'[8]

Denford remarks: 'Losing and being deprived of one's non-human environment and the specially valued objects in the old environment play a large part in the immigrant's development – as decisive as losing or being deprived of the presence of loved ones… This would help explain why many emigrants try to take all their belongings with them, irrespective of their utility.'[9] Absence of such belongings may lead to psychological upset. A case of a patient requiring psychotherapy quoted by Grinberg refers to the therapeutic effects of being surrounded by the familiar household goods. Ever since she had arrived in the new country, this person complained, 'my dreams have been completely crazy, they didn't feel like my dreams…. But a few days ago my dreams when back to normal. I think it started happening the day my furniture arrived…. Every object brought back memories of a situation, a moment, a past. I felt more myself.'[10]

3. PSYCHOPATHOLOGY OF MIGRATION

Psychopathological issues affect the migrant from the very beginning. First of all there are anxieties, depressive anxieties as well as confusional anxieties which together make up the 'Psychology of migration".[11]

Psychological upset affects people in different ways and to different extents. The possibility that people react differently to a strange and often hostile environment has hardly ever been taken into consideration in the study of mass migrations. Psychological tests are not normally required as a qualification for migrating. However, there is a hypothetical 'migratory fitness scale' according to which migrants vary widely. Those who happen to be less fit on such a scale are more likely to find that their latent tendencies will eventually develop into a serious psychic disturbance. Whether an individual succeeds in the process of integrating within society depends on the degree of 'migration fitness', including 'the subject's capacity for tolerating change and loss, the capacity for being alone, the capacity for waiting. In sum it depends on the subject's mental integrity."[12]Eva Hoffman in her autobiographical memoirs *Lost in Translation* refers to this issue:

> "I have contracted this American disease, and now I have to get the American cure, " I tell my shrink accusingly.
> "And what's the disease?" he asks politely.
> "Anomie, loneliness ,emotional repression, and excessive self-consciousness…."[13]

Depression is often one of the outcomes resulting from inadequate adjustment. Environmental factors play a very significant role in such disorders, although the tendency to depressive states may vary greatly from individual to individual. Such was the predicament of the character in Daphne Marlatts's *Arriving at Shared Ground Through Difference:*

---

[8] Naipaul,V.S., *The Overcrowded Barracoon, Deuthsch,* London, 1972, p 37.
[9] See L. Grinberg & R. Grinberg, *op. cit*, p 80
[10] *ibid.* p 80.
[11] *Ibid.* p 161.
[12] *Ibid.* p162.
[13] E. Hoffman: *Lost in Translation : A Life in a New Language.* E.P.Dutton, New York,1989, p268.

> Her words , her very style of speaking derided by her own children, her colonial manners and English boarding-school mores dismissed as inappropriate by Canadianised daughters who denied any vestige of them in their own behaviours and speech, she withdrew into chronic depression and hypochondria. "unbalanced." "Loopy."[14]

One could make a catalogue of the psychological disorders that migrants may experiences, as follows:

- Panic attacks,
- Feeling of persecution,
- Regression to a more dependent state,
- Feeling of anguish, depressive anxieties which may be of a persecutory or confusional type,
- "delayed depression",
- paranoid anxieties which may escalate into true panic reactions,
- the feeling of "being nobody",
- feelings of insecurity, isolation, loneliness, and a weakened sense of belonging,
- hypomanic states, manic reactions,
- hypochondria, (including hypochondria of money" – a fear of poverty and homelessness), which may develop into frank psychotic states,
- mania, paranoia, with persecutory delusions, confusion and disorientation.

V.S.Naipaul, in his book *The Mimic Men* refers to his early days in London: "…it is only now I see that all the activity of these years, existing as I have said in my own mind in parenthesis, represented a type of withdrawal, and was part of the injury inflicted on me by the too solid three-dimensional city in which I could never feel myself as anything but spectral, disintegrating, pointless fluid…"

4. PSYCHOSOMATIC MANIFESTATIONS

Not infrequently, psychological problems become translated into psychosomatic symptoms, often without the person concerned having any appreciation of the root of the problem. These could be interpreted as the individual's attempt to introject and internalise the various threatening stimuli.

The stress of a new life can lead to multiple ailments, physical as well as psychosomatic. A character in Mistry's *Squatter* discusses the problems she had developed, which included difficulties relating to swallowing and constipation. She remarks: "We all seem to share a history of similar maladies, and regularly compare notes. Some of us thought these problems were linked to retention of original citizenship. But this was a false lead."[15]

On a more serious note, however, there is no doubt that the list of psychosomatic symptoms is long, and the conditions can be very disabling. These include: disabling backaches, uncontrollable headaches, digestive symptoms, symptoms relating to stomach ulceration, respiratory difficulties, circulatory manifestations, including high blood pressure, as well as proneness to accidents at work and at home etc. The employment statistics confirm the high rate of these maladies among migrants. A considerable number of them have a psychosomatic basis.

---

[14] D. Marlatt: "Arriving at Shared Ground Through Difference". In*: The Arnold Anthology of Post-Colonial Literatures in English*. (Ed) John Thieme, Arnold, London, 1996, p 875.

[15] R. Mistry, "Squatter". In: *The Arnold Anthology of Post-Colonial Literatures in English*. (Ed) John Thieme, Arnold, London, 1996, p 918.

Two points need be made about these symptoms. Firstly the importance of distinguishing a physical disease from a state of malingering. The classical case is that of backache, a very common complaint among working-class migrants. Notoriously difficult to diagnose fully and adequately, migrants have often been accused of malingering whenever they complain to their doctor about a backache. While this may indeed be the case in certain instances, one has to bear in mind that migrants, exposed as they are to the hardest and most menial jobs available, are far more likely to experience injury to their backs than the average pen-pusher.

The second point refers to the tendency to dismiss patients with psychosomatic disorders as being somehow less significant than physical disorders. It is to be pointed out that from the patient's point of view there is no significant difference between one and the other. There is no significant difference in the symptomatology of a stress-induced peptic ulcer and one which results from a *Campylobacter pylori* infection

5. CONCLUSIONS

Health issues in migrants is a subject that has not been adequately studied. Most researchers have concentrated their attention on comparisons between prevalence of disease in migrants and that in their compatriots who stayed at home. Such studies have shown that that the pattern of diseases in migrants approaches that of the host country population over a period of years, highlighting environmental components as a cause of disease.

There are also a number of genetic disorders which are more common in certain migrant groups compared to the host population. These include disorders like thalassemia in patients from Mediterranean or S.E. Asian origin, or multiple sclerosis in migrants from cooler climates.

What I have discussed here relates to some of those disorders that are the direct consequence of the process of migration and which afflict migrants from any country and from any racial group. In other words, those conditions that arise by virtue of leaving one's own familiar surroundings, friends and family, and having to start all over again in a relatively forbidding environment.

It is my belief that neither migrants nor the health-related professions are adequately trained to recognise these symptoms and to associate them with the migration process. There should be more training to help them recognise the symptoms, their diseases and associated problems as early as possible and to deal with them. The migrant, as a potential patient should also be made aware of the possible cause of turmoil which may cause symptoms and eventually serious disease.

Migrant leaders in countries like Australia and Canada which receive a huge number of migrants have long been aware of the need of providing ethnic-specific services which ensure familiarity and understanding between health care professionals providing the services and their clients. Without such understanding it is likely that these conditions will remain under-diagnosed until they blossom into advanced stages of disease.

LIMITS OF AGENCY IN TRINIDAD AND ALBANIA

Roland Littlewood

University College London, U.K.

Department of Psychiatry
University College London
Gower Street
London WC 1E 6BT, UK

Tel: 020-7679-9479/8
Fax: 020-7679-9426
E-mail: r.littlewood@ucl.ac.uk

If anthropology has always been the reading of local societies in the language of the ethnographer, then there is nothing so very problematic in the idea of a comparative anthropology. Since Edward Tylor, the aim of comparison has always been to achieve higher-order analytical generalisations. Comparative anthropology is back in fashion. Tylor suggested that if you construct an analytical grid of kinship, social organisation, marriage patterns, productive forces, etc. and map it against more evidently local idioms of interest to social anthropology – beliefs about illness, about the self, the role of women, religious ideas or sorcery – you could show the association of the latter – what Tylor called "adhesions" (correlations) – with the former. A more recent equivalent ofTylor's aspirations was the Human Relations Area Files popular in America in the 1950s following George Murdoch's *Social Structure* in which each society studied by anthropologists would have its ethnography divided up into comparable chunks suitable for multivanate analysis eventually by a computer. This approach was never very popular in Britain, both because the items of interest were selected and catalogued according to the subjective interests of the anthropologist, and were thus not directly comparable but because the boundaries of the items of interest were of different sizes and fits. Is the monotheism of Islam of the same order as the monotheism of the Mbuti Pygmies? And is clan A of some community a different social group from clan B of the same group? Thus in one society, 'religion' might shade into witchcraft; in another gender and religion might be inseparable. So how could one take religion, witchcraft and gender as discrete categories whose mutual assortment could be assessed? As Evans- Pntchard put it in his lecture of 1963 *'The Comparative Method m Social Anthropology'* – or rather as Rodney Needham rephrased Evans-Pritchard, "social anthropology if it is anything is a comparative science. And that is impossible".

Evans-Pritchard restricted himself to comparisons within a loosely similar group, African or East African, to show how when certain features like environment were

held constant, variants in culture could emerge in constant patterns, like kingship with settled agriculture (Fortes and Evans-Pritchard 1940). But at the same time, we do make certain generalising assumptions – as the ordering of any elementary textbook of anthropology will tell us: total war seems associated with industrialised societies, or at any rate with large-scale civilisations; as does individualism. Gender equality seems more common in both technologically simple small-scale gatherer-hunter communities and in post-industrial globalised societies. And so on.

Whilst any sort of comparison outside regional comparison has become suspect because of our doubts as to the universality of our analytical categories and models, recently there has been an interest in comparing rather different societies to see what comparisons and constants, if any, might emerge; for instance Michael Lambek's and Andrew Strathem's *Bodies and Persons* which compares Africa and Melonesia, which does not attempt to generate higher order empirical constructions, but with looking at how apparent similarities might actually differ at the ethnographic level. The recent impulse was for Melonesianist enthusiasms for person, affect and partible embodiment to be refracted to Africa: a reverse of the 1950s extension of Africanist models of social organisation to Papua New Guinea Highland societies. Whilst sympathetic to Marilyn Strathem's "aiming for comparison with the non- comparability of phenomena kept firmly in mind" (Strathem 1990: 211), the book concludes that the currently fashionable 'Melanesianis' of anthropology – the notion of individuals, partible persons or the privileging of gender over sex – are not applicable generally.

Without returning to the old question of the distinction between a more individualised self and psychology which is modem and Western, as opposed to a notion of the person which is more enmeshed in the social position of the individual, this paper is an attempt to see how in two different contemporary societies, with radically different histories, constraints on something like what we term 'agency' are locally understood and experienced. My two societies are the north coast of 'African' Trinidad (Note 2) some ten years ago and contemporary post-communist Northern Albanian mountain villages today (Note 3).

Black family life in Trinidad and Tobago resembles that of other parts of the English-speaking West Indies: relatively flexible cognatic kin relations, with shallow 'lineages' of title (surname) through the father if parents are formally married (Littlewood 1993). Personal economic ties are developed through acquired dyadic relationships rather than through kinship or even residence. Although scholarly debate continues as to the legitimacy of the African heritage, the consensus is that contemporary working-class patterns of life owe more to the continuing relationship between Black and White, between island and metropolitan country, than to any African 'survivals': one element of the Western working class, a 'rural proletariat' as Sidney Mintz (1974) has termed them. Trimdadian ethnographies emphasise the free floating, individualistic

and context dependent nature of the local, 'according' ethos (Rodman 1971, Littlewood 1993): norms are statistical rather than prescriptive, and strategic self-interest legitimate.

During the 20th century, Albania has remained the poorest part of Europe isolated from the rest of the continent by geography and politics. Despite attempts at centralisation from Tirana, rural life was dominated by a network of exogamous patrilineal clans, often called "tribes" (*fis*; or in residential terms *baijraks* or Banners) especially among the Ghegs of northern Albania. My villagers could trace their agnatic line back to the 14th century with a fair degree of correlation with local historians (Smajlaj 2001). Without a nationally enforced system of justice, customary law prevailed among the transhumant peasants Inving in wooded multi-generational family settlements (*shtëpi*). The majority of Albanians are Muslim, with a Catholic majority in the north and an Orthodox in the south. In spite of the Hoxha regime's opposition to the traditional social order and to religion (Albania was the world's first "atheist state"), notions of the customary law remain to adjust personal relations in what is once again a clan based society with limited central authority. The most influential of the codifications of this law is the medieval *Kanun* (Canon) of Lekë Dukagjini (Littlewood 2002a) collected together with 20th century revisions by a Kosovar priest in the 1920s (Gjeçov 1989), presumably in an attempt to standardise and attenuate more inchoate forms of immediate revenge (Black-Michaud 1975) "The importance of the Kanun to the ordinary life of the Albanians of Kosova and the Matësi [mountainous northern Albania] can hardly be exaggerated" says the Balkanist historian Noel Malcolm (1999: 17). "It still influences life in the entire area . . ." (Senechal 1997: 5), and traditionally took precedence over state or church law (Gjecov 1989) (Note 4).

Striking similarities have been noted between the Kanun of Leke and North Caucasian customary law, and indeed the Indian Laws of Manu (Gjeçov 1989). Whilst much of the Kanun is taken up with marriage, hospitality and the resolution of rights in livestock and property, it is most well-know in Western Europe for its regulation of homicide and blood feud *(gjakmarrje)* of the type associated with other Mediterranean societies such as Sicily or Corsica (Note 4): particularly since the translation of the Albanian novelist Ismail Kadare's famous *Broken April* (1991). One of the most striking aspects of this ethnographic novel and the Kanun which it illustrates is the location of experience and revenge within the standardised setting of the Kanun itself; as if individual perception and experience are of no real significance in the working out of the process of the local moral economy. However it starts (quarrels over boundaries or grazing rights, insults to guests or women), its continuation has an almost inexorable public form. On the death of a man in feud, his blood-stained shirt was hung up: when the dried blood turned yellow, it was then time to avenge the death. Each male

relative (defined on segmentary principles) of the killer has *dorë vete* (‘the same person’s hand’); they are all equally responsible. One of the aspects noted by commentators on the blood feud (Durham 1909, Hasluck 1954 Kadare 1991, Senechal 1997) is how little individual motivation to continue the feud is actually determined by feelings of loss or personal revenge: all the commentators note that it is the expected public response to an insult to the “law of blood” (Durham 1909, Hasluck 1954): “Till you had takenblood everyone would talk about you. You could not live like that” (ibid: 112); “strangely impersonal, abstract . . . the blood feud is a collective concept involving the whole community” (Senechal 1997: 29, 30). An individual engages in return assassination because he must, as part of the accepted order: he goes into ambush, shoots a male member of the opposing family, carefully turns him on his back and places his gun by his head (as the Kanun specifies: §3846 (Gjeçov 1989)), goesback to his own family stronghold (*kulla*) and sends a neutral messenger to the opposing family (or tribe in the case of inter-tribal feud) stating what he has done and claiming a period of *besa* or pledged truce, during which he attends the funeral and wake of his victim in the latter's house, pays a monetary compensation to the ritual authorities and then awaits his own death (or that of another male family member) on completion of the truce: “For a moment he felt as if he were trapped in bird-lime by the bloody part of the Kanun” (Kadare 1991: 30).

Agency and Volition

I’ll start my comparison with a hypothesis: m most, probably all, societies, everyday action is understood and experienced as volitional – as the freely chosen action of a person acting with full agency. However in certain circumstances, this agency is seen as restricted by certain constraints: as what we term bodily diseases, by the actions of others or just by agency having a more restricted sphere in which it can act, as in madness (Note 5). Anthropology furnishes many classic instances of the latter restricted agency. Thus says Lienhardt (1961), emotion among the Dmka of the Southern Sudan is ‘made’ by the actions of others. And in the same way. Western European societies would recognise “being taken over” by an emotion like anger such that we cannot act with our usual equanimity. Note that the everyday state of presumed volition is seen by us as the normal (with methodological problems for them looking at what we call altered states of consciousness [Littlewood 19961 (“Reason and Necessity”).

In this paper I want to compare my two rather different societies – northern Albania and northern Trinidad. Both nominally Roman Catholic, Trinidad may be considered the first “modern” society in the world, in which slave-bodied capitalism provided a whole new model for human relations, in which humans became commodities. After slavery ended, West Indian societies formed what Mintz (1974) has called ‘reconstituted peasantenes’ but their close relationship to Western values of universalism, Christianity and the world economy, were relatively unaffected.

century; and in the case of blood feuds and *fis* kinship still continue today (Note 6). In Hoti. northern Albania, marriage and alliance are still exogamatic, alliance segmentary and kinship agnatic.

In both societies, individuals are held to be accountable for immediate actions: for saying one thing rather than another, for their decisions and their physical movements. In both, it is recognised that you can think before you act, and this establishes personal responsibility. In both, physical disease is recognised as a restriction upon action, a limitation not on volition but on your performance of it. Now for the differences: what we may gloss as 'psychological dysfunction' is clearly divided in Trinidad into the discrete categories of *madness*, *malkadi* (epilepsy), *doltishness* (senility, mental handicap) and *maljo* (evil eye) (Littlewood 1988).

Madness is called *folie* in Creole and is also variously known as *crazy*, *offkey*, *off the head, going off*, *loco*, *kinky, head ai' right, ai' right dey*, *ai''collective*. It is recognised through continued unintelligible behaviour which is quite meaningless:

"They would do something opposite to your sense: so we style them mad people. Something unusualin madness but they selves ai' know they mad. They climb a pole; go in water; they feel they bathe when it have sun; they out of memory – they don't know what they do; they just pick up a cutlass and chop someone, or pick up a baby and dash them in road; cuss, lie down in the centre of the road; always do strange things other don't do; take he clothes and burn it up; burn house; launch boat and go out by heself."

Other mad actions commonly cited are eating plantain skin, garbage and raw food; walking around naked; touching people who pass; walking in the hot sun in the middle of the road; staring at the sun or the stars; failing to recognise people; refusing to comb one's hair; bathe or accept the help of others. One villager I knew had been in St. Ann's, the psychiatric hospital in Port-of-Spain. for many years. He was discharged home to be visited at intervals by a nurse for regular injections. Any initial sympathy for Thomas on his return was rapidly forfeited by his ungracious behaviour. His brother built him a small wooden house on family land 'but he just mash it down'. When I was in the village, he had stripped his hut of its walls for firewood for cooking, and it consisted of a leaky roof, the house posts and some floorboards. He is given old clothes at intervals but cannot always be persuaded to wear them. Thomas is seldom seen in the village, usually disappearing into the nearby bush or greeting any passerby with surly and unintelligible mutters.

The madman is described as loud, boisterous, erratic and potentially explosive. His most frequently mentioned characteristic is his violence: "They just do anything that get in their way". Stories circulate in Trinidad about the dangers of St. Ann's Hospital

and I repeatedly heard one about “this madman a few years back take a knife and stab the boy in the next bed”. Other patterns of behaviour may superficially resemble madness: “A child behave as if it mad but it ai’ mad”. The confusion of the madman is to be distinguished from that of becoming bazody (dizzy), for instance in the crowds of Port-of-Spain, particularly during Carnival. The bazody person soon recovers and the state, although it may be associated briefly with bizarre behaviour, is always intelligible through the immediate precipitants. Drunkenness is also akin to madness for “When you runs a drunk you do similar things, you part mad”. The drunkard however can always be distinguished by his staggering gait and slurred speech: “The mad must walk straight, they just do funny things. He has a different expression on his face – he look kind of wild. Mad person’s eyes got wide and staring you, staring you; if they sit down nice, all of a sudden they want to make a sudden grip”. The madman is best avoided unless they are a relative or old friend. Talking to him is not going to help anything. Nor will he be grateful for anything you might do to help so, as you may get hurt, ‘pass by a next way.’ He is living in a private world of his own: “They laugh so, just by themselves. Tell them howdy and they ai’ tell you. If you carry on a conversation, they on a different [one]". Madmen say things which are manifestly not true: “These imaginations they put on a real side. From the time it reality, you sick”.

When a villager meets Thomas, “Thomas pass by me and he say “Right!” [the customary short greeting] and I say “Right!” but I don’t go near. I keep to myself. Madness is hardly catching – “though some say it do rub off”– but it always carries a potential for physical aggression. If violence occurs, the police are always asked to take the madman, sometimes via a magistrate, to the mental hospital. If he is feared it is for reasons of personal safety, not because of any ultrahuman influences. Pinnacle villagers maintain a robust attitude to the mystical, and Annette, an elderly widow who is half-seriously regarded as a *soiiconyant* (vampire), is not publicly shunned, far less accused, although significantly she has few intimate friends.

If they do not appear violent, mad people in Trinidad are often treated with derision, and the nurses at St. Ann’s say many of their ex-patients carry a cutlass or stick to protect themselves. The assumption of violence can be used by madmen to obtain food; a patient in the hospital told me that he used to go round town saying “I from St. Ann’s, I’ll kill you” in a sometimes successful attempt to get food. For the madman, St. Ann’s is indeed a refuge from living in the streets, and staff are frequently called to see an old patient who is threatening the police: “If you ai' take me in I gone lick you. I have my pern-lit for St. Ann’s [i.e. a previous admission]”.

A common but unelaborated explanation of madness is that ‘some bom mad because it come down in the family’, either because parents or grandparents are mad and it is somehow passed down physically in the body, or because spirits sent against others may return, not to the sender but to members of his or her family in a later generation.

Similarly God may punish family members other than the one with whom He is angry. Other villagers dispute this: 'You ai' bom with a weak brain: it have to have something make vou mad'. Although latent from birth this sort of madness does not appear until adolescence or adulthood. Its potential passes down through men or women and gradually disappears in successive generations.

Other common causes include summoning up spirits, or being cursed by a priest or nun, or worries (*pressure, grinding*) or abandonment by a spouse (*tabanka*). Whatever its origin, madness in Trinidad is generally referred to as an all or nothing condition, total and effectively untreatable: "Once mad always mad". Some argue that the brain is physically altered, others just that the mind is 'taken over': what is actually happening inside one's body when one is mad remains mysterious and of little interest. But all agree that the madman must be taken to St. Ann's by the police. This is for public safety, not for treatment, as there is nothing the doctors can do. Madness induced by a spirit, the most commonly cited cause, cannot be removed without God's rare intercession. In conversation, madness is usually ascribed a discrete external cause; even informants who advocate the "pass down in family" theory feel that the affected individual needs more than a predisposition. In practice, when dealing with local instances, a more complex set of explanations is offered by villagers which do link madness to individual personality and everyday life; madness in a friend or relative may be the consequence of *studiation*, of receiving bad news, of *pressure*, *grinding* and *tabanka*, or of the pursuit of *vices*. Tabanka is when a man is deserted by his wife. It is in these particular experiences that we find a path from everyday life to madness which implicates an internalised set of mental attitudes or psychological processes.

Studiation refers to both the study of sorcery but also to any undesirable habit ("they study meanness and commonness") or to excessive mental emphasis or opinion on any subject, especially when acquired through reading: "You overpower with pressure of study. We have young people at school an' they can' take it a next time. You overleam an' you brain too light, it worry you head". Studiation madness is rather different from the otherwise undifferentiated picture of madness: it is recognised through social withdrawal (becoming selfish), aloofness, emotional distance and ultimately total self-absorption. Some villagers in any village felt that the Europeans – cold, supercilious and self-centred – have become like that through their books: the White temperament is, as it were, studiation madness spread out thin. Theological speculation when reading the Bible, a common village interest, is particularly dangerous: "scripture hell of a thing, it send you mad". Excessive study of any type may be described as travelling, lost in a personal world, out of touch with reality. Studiation has a morally as well as a practically ambiguous connotation, as if, like sorcery, it somehow involved unhallowed domains; certainly book study is not regarded highly, for it involves leaving the community for self-betterment, a denial of local solidarity. Those families who encouragetheir children to leave Pinnacle to

continue their education – and who take on the whole respectable package of restricted public drinking, sobriety, hard work, saving, church attendance, reading the weekly *Catholic News*, not going *bare back* if they are men and not wearing trousers if women – are accused of being *social* (pretentious).

Studiation is not only an intense concentration on books but preoccupation with anything, particularly worries or slights which cannot be resolved. The breaking of bad news too harshly or too suddenly may precipitate madness by causing overwhelming *pressure* (sudden worry). It is sometimes likened to a blow on the head: "That could worry you" head, even send you crazy a time. It have a woman in Blanchisseuse an' they come an' say she man drown off Tobago an' she bawl and carry on an' she crazy for truth. They take she up to the mental". But such madness is usually short lived: "If you frighten, blood fly to you head but you ai' mad all time. If you get good care it stop, it don't even last a week on you. They put ice on your head I hear but I ai' sure". More rarely:

"Something went on with the man Veronica live with, and they say it a woman he have who do nastiness [sorcery]. I don' think that. It was something he do. It come like worries. He don't sleep in the house two nights, an' she bawl an' carry on. She asked 'Is your husband?' An' she say no but you can see. She bawl, run about, wave her arms. When they rush to hold her she say 'Don't hold me!' She could damage you or bite you. They call me – my mother was a friend of she – 'Veronica like as if she going mad'. I scared like hell an' ai' go. An' he go away down the Main an' they go an' tell she. She start getting worse and want to grip an' she start call this man' name an' this woman', this black woman, an' that why they say she got something on her. She go to mental, an' she ai' you know you, an' she quiet an' unconcern'. She big an' fat. She got blind. Is she blind now? I don't know. An' she have two children for him, an' he worthless nasty man".

Pressure refers simultaneously to such worry and to the subjective and external 'pressures' of work and poverty, but also to *high blood* or *high pressure*, understood variously as over-rich blood, the recording on the doctor's plethysmograph or blood passing up to one's head. "Pressure come as a new thing but now it common in the world. It have blood thickened and heated so it can' flow too good. Once it in you, if you get vex it raise'. It may be caused by using fertilisers on the land. Low pressure is experienced as weakness and thus Guinness stout, used as a build up, may cause high pressure. Pressure is used to explain everyday fluctuations in wellbemg and some villagers say it is 'hot' and can be relieved by a cooling tea. It certainly builds up like heat or gas and has to be released: worries and anger should be verbalised and ventilated, and not retained inside by *studying* them, grinding away. Otherwise they cause high pressure and possibly madness: 'Inside here does eat people'. If one has angry feelings against another they should be freely expressed, at any rate in theory. In practice one runs the risk of being accused of stirring up *comess*. ('I was going to

answer but Rupert say she ignorant [badly behaved]: “Don’ answer, it make enemy”. But I have to tell she! Better than keep inside you and worry worry”.) All strong feelings including one’s nature (sexual desire) should be released lest they develop as pressure. “Cooling it” is less suppressing an emotion than releasing pressure slowly by relaxation, by liming.

Both physical sickness and madness refer us to the therapeutic efficacy of what we may term ‘catharsis’, the expulsion of something undesirable to return to a previous and balanced state. We find it in the notions of heat, pressure, grinding and tabanka. It is recognised in the national institution of the annual Carnival: “It amazing what we Trims put up with an’ don’ explode. But come Carnival it JUS” baccanal ... You free up you self, you ai’ got pressure, no one looking at you”.

Continued anti-social behaviour so persistent as to constitute a vice – stealing or violence – may be regarded as an attenuated form of madness, reminiscent of the psychiatrist's “psychopathic personality”: “It ai’ just a vice. He ai’ really bad. He ai’ exactly what you call mad. It come as what we call half-way crack’. The diagnosis of madness is amved at subtly, pragmatically. It is always ‘according’. To take a local instance:

“An’ my friend Marcelme been start talk queer like she go crazy. An’ I take she to a woman and she say, ‘It have one throw something m you’ yard. If for you’ mother but it hit you’. An’ the girl still half crazy an’, after her mother die, she go to mental, but she cure in a few weeks. She ai’ crazy because she got cure. It have to be something that an enemy put on her”.

In Albania, mad (*budallë*) is the village terms, *çonendun* the more medical (perhaps equivalent to psychosis). One who is *budallë* doesn’t walk normally, clothes are missing or open (again he may go naked), but otherwise they don’t look abnormal. The main characteristic is that they don’t think about or examine what they do; they speak nonsense, talk to themselves and make strange gestures. “All your life there is something missing, like intelligence”. You can tell a *budallë* from a drunk (*dukur*) because the latter crashes into things and people, mumbles, staggers about and is potentially dangerous with apparent fearlessness (what m Tnnidad is called *bravo danger*).

If mad in Albania, you are seldom dangerous (here a big difference from Trinidad) but “everything you do for him, his mind turns back” Most are bom mad but you can go crazy because of your economic circumstances but not little stresses, and again if you study too hard: “my mother said, stop reading, don’t study too hard, you’ll go mad”. They become withdrawn and distant. Any reading not just studying. Leaving the community to study is valued: to get on you must get out. Georgi became ill when he was about 20, after smuggling horses over the border; he was captured by

Montenegrin soldiers who kept him in prison and beat him about the head. On returning to Albania he spent months in hospital, and then went mad. It's not clear whether this was because of physical or psychological trauma.

When pressed, witchcraft or "evil eye" or "black shadow" can send you mad according to some but these ideas are not very elaborated. There is no equivalent to tabanka, for here it is men who are made of sterner stuff. What happens if your wife betrays you? "Men are stronger, they would say they have never loved her", but they pass "a bad time, not eating and drinking too much". But not going mad.

Again, there is no local treatment for madness, and as in the Caribbean, you have to go to hospital, although medical practice is viewed more optimistically in Albania. Madness is again used in a 'weak' sense – p*rej budalla* – to an inappropriate action, decision, gesture or talk, without the sense of being really insane. Whilst there is not the neat sort of nosology there is m the Caribbean, *budallë* is distinguished from: sakat (deformed, cross-eyed, he can't work or talk) and: *prapambetur* (mentally handicapped) – "one without the abilities of others" – usually on the basis that you are born like that, whilst you acquire.madness. There is no local word for senile unlike Tnmdad – just "old man" or "woman", although there is in my dictionary – *pleqërie* which in the village is just used to mean an old person.

And *budallë* in my dictionary of "literary Albanian" (Note 8) (Hysa 1997) means half-witted or stupid. So at the village level, there is not the exact differentiation we might expect from the dictionary or the Caribbean data. Madness is mysterious, something in the brain, and of no great interest. Georj died in the hospital, rumoured by the village to have been killed by other patients, "the strong steal from you and beat you – and you starve": not so different from the Caribbean view of the asylum. But in Albania you try to keep the mad-person at home, in Trnidad you call the police. Both offer environmental causes, something like 'psychological pressure' in Tnmdad, economic worries in Albania. Both counsel against excessive worrying. But madness in Albania is relatively unremarked, a mysterious disease, and one which does not carry much ideological baggage.

By contrast however the arbitrary eruptions of madness in the Caribbean do not escape social meaning. If it usually represents a discrete and easily recognisable state, it also provides in practice a rich and *according* term for other, more ambiguous behaviours, and an image to describe those who are 'too clever' or antisocial to Join m daily concerns. Even in the 'strong' sense, madness recalls the demotic values of reputation; the bush as opposed to the town; Creole rather than English: *outside* rather than *inside*, the vices of obeah, ganja and excessive drunkenness. The ultimate image of the worthless man, of vice carried to its logical and inexorable conclusion, of unsocialised nature, is the madman. It was V.S. Naipul I think who said that no West Indian short story is complete without its statutory madman. If tabanka and studiation

madness can be interpreted, as I have done, as ironic commentaries on selfish and pretentious attempts to imitate White and middle-class life when this is not 'according to circumstance', vices warn of the opposite danger – that of abandoning *social* life altogether. Tabanka may be read as the over-valuing of respectability as a practical goal, while vice is its under-valuing. Failures of balancing interests against possibilities they both lead to madness, the caricature of the impoverished and *worthless* Black. Neither are simply 'indigenous' explanations of sickness, independent of external constraints. Both are rooted in the economic history of the West Indies, in the inescapable irony of being poised between two ascribed sets of values, one derided as worthless, the other only precariously attainable.

One other limit on your personal agency is however very similar in the two contexts: evil eye – in Albania called sy *zi* (or black eye), in Tnmdad – *maljo* (from the Spanish for bad eye). These are very akin to general European notions of evil eye: a power to damage others which may be unconscious (like witchcraft among Evans-Pntchard's Zande) and which is inherited. And which power you can protect against by blue bottles in Tnnidad, or blue or black amulets in Albania and also animal skins, horseshoes or dolls put up on houses being built. In both countries, it is women who know the words to cure damage to livestock or young children caused by evil eye; in Tnmdad these are supposedly secret but 1 was told some – old Latin prayers mixed with apparently nonsense 'Yarriba' (Note 7) Creole words, but nobody would tell them in Albania - "it's women's words, and it's women who put the devil in a bottle" (i.e. women are so devious they can fool even the devil). In both countries, there is ambiguity over whether it is indeed unconscious, or whether the person affected can will it; in Albania, this sort of more 'voluntary' evil eye is called *hije e zezë* ("black shadow") but is not so severe. If a man with "black shadow" talks to you before midday, and you answer without asking a question, you miss the bus, the plow slips, the goat get lost: "Ifs best to go home and go to bed".

How may volitional actions become limited? Take the Trmidadian idea of vices (Littlewood 1988):

We can gloss we as 'addiction': a fixed pattern of activity, initially chosen freely by people because it is pleasurable although it may be harmful to themselves or others, and which becomes increasingly difficult to resist until it dominates and eventually destroys them, no longer an object of choice but a part of their being.

Thieving is a vice which becomes impossible to stop when a victim solicits God's justice by lighting a candle on you. God may himself intervene independently with similar consequences, but some suggest that just stealing by itself has an effect on the thief, compelling him to engage in it with fewer and fewer precautions against detection until he *get spoil* – he is caught or becomes mad: "Their hand fast, they can' see without taking". A compulsion to repeat stereotyped acts is also found in the vices of

high science and obeah when, eventually, a spirit one has conjured up returns, or else God decides that enough is enough. Sexual activities which are vices and which may end in madness include male and female homosexuality; sodomy with people or animals; or sexual relations within the prohibited limits of affinity, all totally unimagined patterns in Albania. Rape was unknown in the village but was regarded as an unacceptable extension of normal sexual life rather than a vice. (In Albanian villages, rape is believed to be impossible – the woman must always consent – and therefore is to be held responsible.) When I asked if there were any other vices in Trinidad, a few suggestions were offered including sex with children and the sadistic beating of members of the family. Persistent lying, quarrelling, making comes, gambling at whe-whe, bad-talking, denying the power of God (usually associated with science), smoking tobacco and laziness are not really vices but they are often dismissed as such in the heat of argument.

Vices are continued patterns of action and personality which are generally socially unacceptable. Frequent public drunkenness and the use of ganja, although they are the vices most often volunteered after obeah (at least by the more respectable villagers), are rather different. Apart from the local Adventists no one regards moderate rum drinking as a vice; on the contrary, it is a welcome lubricant to village life, but continued excessive drinking, as determined by its visibility and its consequences, is a vice which can lead to madness. Smoking of ganja (as opposed to using it as bush tea) is a vice according to the older women. Not so, say the young men, although they agree it can send you mad if 'you can' take it'. Similarly, heavy drinkers believe that rum can cause madness if 'you got a weak head'. While vices may be cited as moral offences, they are usually criticised for rendering normal social life impossible, as contraventions of the natural fitness of things: 'I feel man should be man and woman woman. The way you made. This kind of filthiness [homosexuality] is a bad thing because God make a partner for you. I don't like it, they dress and speak like a woman'. By contrast, in Albania, women do dress as men when they are 'sworn virgin' – but as a social not a sexual act.

In theory no particular personality in Trinidad is more liable to a vice. It is the sort of thing anybody may be tempted to do in a weak moment. If one has a vice one should keep it secret for to flaunt it suggests it is already taking you over. Nevertheless, accusations of vice are directed against those who are already *worthless* and thus probably have other vices. Any sexual vice can lead to implications of obeah, and both are known by the general term of *filthmess* (or *nasty ways*) which is worthlessness and confusion taken further. The term *interference* locally denotes both obeah and sexual vice. A whole family, through past misdeeds or obeah, may be *blighted,* the same term which is given to the victims of maljo, although here suggesting an inherited tendency to engage in obeah, thieving and other filthiness, the whole complex inexorably moving to general incest and insanity. If your father was mad, ran a drunk or had a reputation for science, you are regarded as that much more vulnerable As

with any specific vice, a blight on a family or individual may simultaneously be taken as past divine punishment and as the inevitable working out of a current vice.

By contrast in Albania, the dictionary words jepem and *fanatik_* both glossed as ‘addition’ have no local meaning in the village. Martin, who is always drunk, had been a member of the Communist Party, and left the village to take a degree at a Party educational college; after 1992 he joined the opposition Democratic Party (soon to be the government) but now nobody on either side trusted him; he couldn't get a job, and he was hopeless at farming. “He gets bored, he is poor but he has to feed his family, each day he gets up, feels bad and drinks to turn his mind away from it”. If he got a job, he would surely stop drinking. And Martin himself says the same. And gambling similarly is seen a dependent on poverty, on external circumstances. For example in 1993, by smuggling petrol and goods to Montenegro (during the Bosnian war), the village was temporarily rich. All the men were drunk the whole time. the smuggling then stopped, the village becomes poor, drinking stops. There is no consideration of internal motives, no system of personalities or psychology, nor magico-religious psychology; just uniform desires (for money, to feed the family) weighed against material adversity. Why do people become *nevrik* (nervous)? Because of what happens to them. Q: What types of personalities do you have in the village? A: Well, old ones, young ones, drunk ones, that’s all. Using my dictionary, I enquired about various emotions and personality types. Did they exist in Hoti? Yes for ‘greedy’, ‘embarrassed’, ‘miserly’ (everybody). No for ‘addiction’, ‘hurt’, ‘sorry’, ‘depressed’. Are these people generous (*zemermadhe*)? Well they are hospitable (*mikprites*). Q: What sort of person is your cousin? A: well, he'll be the one to fetch me my wife. Q: (Repeat.) A: incomprehension. Q: Why do people do bad things? A: (a) They are badly brought up. (b) Circumstances. Albania is not so much non-psychological; it is anti-psychological.

In Catholic Albania, individual life is suspended. You can't succeed because of the government, because of the gangsters and corruption, because Europe is not interested in us. Nor can you be blamed: except for being a Communist, Serb, a Turk, a Greek, a Muslim or even a Southern Albanian. There is no possibilities of internal (psychological) change at all: everything is external, social and moral, contrasted with the nch complexity of psychological – moral – religious ideas in Trinidad.

NOTES

(1) This paper uses data from fieldwork in Trinidad in 1980-1982, 1988, 1991 and Albania in 2001 and 2002. Fieldwork in 1980-1982 was supported by a Social Science Research Council Post-Doctoral Fellowship.

(2) Trinidad is the most southerly of the Lesser Antilles. Some thirty-seven miles across by fifty long, it lies in the Orinoco delta, eight miles away from the South American Mainland. A Spanish possession until its capture by the British in 1797, it was largely ignored by the Spaniards after they had exterminated most of the native Caribs and Arawaks. Spain eventually encouraged colonisation by French Catholic planters from other islands, together with their slaves who grew sugar in the lower areas to the west along the Caroni River. Apart from a French cultural identity (which necessitated extended Crown Colony status) and the influence of the once powerful local Catholic Church, Trinidad's later history is typical of the British Caribbean: the development of sugar plantations and the emancipation of the slaves in 1838 followed by the introduction of indentured labourers from India together with some free African immigrants from the middle of the nineteenth century; conflict between colonial officials and the local plantocracy; the collapse of the price of cane sugar after the loss of colonial preference and competition with European beet sugar; economic stagnation and imperial neglect; the collapse of the other main exports, cocoa and coffee; the development of Creole nationalism; universal adult suffrage in 1946; increasing local participation in the Legislative Council progressing to internal self-government in the nineteen-fifties, andindependence in 1962 as a single parliamentary state with the neighbouring island of Tobago. The governing parties since 1956 have been committed to a mixed economy and a welfare state. The major party derived its support predominantly from the African population and comfortably maintained power until 1986 through direct and indirect patronage and regular parliamentary elections, apart from racial tensions preceding independence and a brief hiccup in 1970 when an army mutiny sparked a short-lived Black Power rebellion. Trinidad differs from other West Indian islands in its relative wealth from oil and its low population density (with continued immigration during the nineteenth and twentieth centuries from the smaller islands), and also the presence of substantial numbers of free Black Creoles in the period of slavery. The White French Creoles only stopped speaking French at the beginning of this century, while the last Spanish courts were abolished as late as 1879. Compared with the rest of the Caribbean, relations between African and European may be said to be relaxed if not altogether harmonious, although discriminatory legislation continued until the Second World War and practical social segregation based on colour lasted well after independence. Colour, class and wealth still run together.

(3) Albanian speakers have been settled in Southern Europe since at least the early medieval period. Coming under the control of the Ottomans, Albanians were then among the last to seek a national identity separate from Ottoman Turkey in the late 19th century. In spite of Kosova having been a centre of resistance to the Ottomans (for instance, the League of Prizren in 1878), when Albania achieved independence from Turkey in 1912, the are east of the Accursed Mountains, Kosova, was occupied by Serbia in 1913, and has remained part of Serbia and thence Yugoslavia. During the First World War, Kosovan Albania was the seat of fighting by various groups of Serbs, Greeks, Turks, Macedonians, Italians and Britons, but the pre-war settlement was re-affirmed by the League of Nations; the boundaries between Kosova and the rest of Albania have remained the same in spite of the recent collapse of Yugoslavia. Albania proper, on the Adriatic coast, has remained independent, first as a republic then as a monarchy under King Zog, was occupied by the Italians and then the Germans m the Second World War, with a period of extreme isolation under the communist Enver Hoxha, and now a return to a nominal parliamentary system but with frequent and widespread civil disturbances often approaching civil war and a vacuum of power at the political centre.

(4) Hutton in 1954 termed Albanians “head hunters” and compared them with the Pushtu and Nagas. Formerly the assassinated corpse was decapitated and the head earned by the extended tuft of hair that Albanian male hairdressing once afforded (Hasluck 1954). The display of expected and permitted grief after a death is still clearly specified by the Kanun: “§1235: The men who bewail the dead scratch their faces and beat their clothes. §1236: The women lament, but do not scratch their faces. §1239: Men do not lament over women, except in the case of a son over his mother or a brother over a sister” (Gjecov 1989). With the frequency of male deaths, women can elect to become honorary males and, declining marriage altogether, inherit and act as heads of households – as ‘sworn virgins’ (*virgjinesha:* Durham 1909), taking on a male *social* identity – and take part in blood feuds (Littlewood 2002b). Homosexuality as a *sexual*_practice is not locally recognised. In both Catholic and Muslim Albanian communities, the levirate (here additional common law marriage to the deceased brother's widow) was formerly practised.

Women had little voice in the Kanun (Doja 1995); they could not be the target of a blood feud, could not inherit,

nor refuse their arranged marriage, were assumed to be virgins on marriage, and must "submit to the husband's domination" (Kanun: §33, §57); "a woman is a sack made to endure" (Gjeçov 1989) – in other words, perform an essentially child-bearingrole as the property of her husband. At her marriage a wife's parents formerly gave their son-in-law a cartridge to kill their daughter should she be adulterous or [betray hospitality" (Hasluck 1954). The association of men with the blood feud is exemplified by the expression for tracing relationships agnatically (recognised descent, through men) "by blood"; through women (uterine relationships) "by milk". The almost erotic symbolism of the man's gun is commented on by Edith Durham (1909: 176): "His 'well-beloved' had cost twelve napoleons the price of an ordinary wife, and he spent eighty guilders a year – exactly half his income – 'feeding' it [buying cartridges]". Durham describes how everyday interest and occupation are monopolised by the "law of blood", and how sardonically but lightheartedly men pursue its course. Women are (like priests) not legitimate targets of the blood feud. The idiom of "blood" thus variously connotes Albanian kinship and thus identity, social position and honour, custom and communal acceptance, masculinity.

The Kanun's regulation of homicide is concerned with individual acts, carefully tallied, often in an interminable sequence of reprisal, which is difficult to break: "At the end of the Ottoman period it was estimated that 19 per cent of all adult male deaths in the Matesi were blood feud murders, and that in the area of Western Kosova with 50,000 inhabitants, 600 died in these feuds every year" – 1 in 400 men (Malcolm 1999: 20). Feuds can be theoretically commuted by paying blood money but this, although allowed by the Kanun, is regarded as somewhat dishonourable, and many a feud previously settled by mediation is opened up again by a young man seeking to restore family honour. Mediation by outsiders, a common occurrence in Arab blood feuds, was relatively unusual in Albania, although sometimes a local priest, mullah or elder could carry this out. Resolved blood feuds may result in "blood brotherhood" and fictive kin links between the adversaries; thus, their families cannot intermarry.

It might be conjectured that the Kanun refers to a now disappeared past yet since the early 1990s, with the decline in communist authority, blood feuds in Albania and Kosova have proliferated with the privatisation of communal land (Malcolm 1999, Schwardner-Sievers 1999, Young 2000) "at a remarkable rate" (King 2000), shading into new urban and rural criminality and now "without order" (Krasztev 2000). A recent study found that over a hundred young boys in northern Albania were in protected hiding, fearing to go out of their *kulla* because of an ongoing feud (King 2000). Perhaps a hundred families in Shkoder, a town of some 80,000, are "in blood" at the moment (Krasztev 2000). A recent case involves two members of the parliament (*ibid.*).

(5) Thus, my comparison only illustrates areas where particular notions of biophysical causality, individual morality and social constraint merge or live in opposition. My title is limits of agency, not limits <u>on</u> agency.

(6) One similarity between the two areas may be argued – slavery and the Albanian period of communism under Enver Hoxha, both in a forced move towards industrial modernity and thus consequent individualism. West Indian slavery however constituted a totalising and radically new order, whilst Albania communism never touched much beyond formal structures in the north where the pattern of subsistence agriculture continued as before. In Rrapsh, my village, the majority of the families had been *famije pessekutim*, officially recognised as oppositional families, often imprisoned and denied access to higher schooling or travel outside the immediate area. When collectivisation, initiated in the mountain as in the 11960, collapsed with communism in 1991, land simply reverted back to the original families, former community being easily integrated back into the structure of the village and the tribe, all without, by most accounts, any serious conflicts.

(7) The local name for Creole words and supposedly used by the Yoruba ancestors of African Tnnidadians, as found in folkloric sayings, plant names and possession by spirits in *shango* or Shouter Baptism.

(8) The unified language based on Tosk (South Albania) and Gheg (North) encouraged by the communist regime. Villagers in Hoti are familiar with it, although many local words or pronunciation (for instance of a fmal e which is silent in literary Albanian) are specific to the region.

REFERENCES

Black-Michaud, J. (1975) *Cohesive feud: feud in the Mediterranean and the Middle East*. Oxford: Blackwell

Durham, E. (1909/1985) *High Albania*. London: Virago

Evans-Pntchard, E.E. (1963) *The comparative method in social anthropology*. Hobhouse Memorial Lecture (eds.). London: Athlone Press

Fortes, M. and Evans-Pritchard, E.E. (eds.) (1940) *African Political Systems*. Oxford: University Press

Gjeçov, S. (1989) *Kanuni i Leke Dugagjinit*. New York: Gjonlekaj

Hasluck, M. (1954) *Unwritten law in Albania*. Cambridge: University Press

Hysa, R. (1997) *English-Albanian comprehensive dictionary*. New York: Hippocrene

Kadare, I. (1991) *Broken april*. London: Harper Collins

King, C. (2000) *Singular oaths*. Times Literary Supplement, 7 July, 27

Kraszter, P. (2000) *Back to the torn-out roots: reflections on vendetta in contemporary Albania*. Conference on "Intersecting Times: the work of memory in South East Europe". Swansea University

Lambek, M. and Strathem, A. (1998) *Bodies and Persons: Comparative Perspectives from Africa and Melanesia*. Cambridge: University Press

Lienhardt, G. (1961) *Divinity and experience: the religion of the Dinka*. Oxford: Clarendon Press

Littlewood, R. (1988) From vice to madness: naturalistic and personalistic understanding in Trinidadian local medicine. *Social Science and Medicine*, 27. 129-148

Littlewood, R. (1993) *Pathology and Identity: the work of Mother Earth in Trinidad*. Cambridge: University Press

Littlewood, R. (1996) *Reason and necessity in the specification of the multiple self*. RAI Occasional Paper No.43. London: Royal Anthropological Institute

Littlewood, R. (2002a) Trauma and the Kanun: two approaches to suffering in Albanian Kosova. *International Journal of Social Psychiatry*, 48, 86-96

Littlevvood, R. (2002b) Three into two: the third sex in Northern Albania. *Anthropology and Medicine*, 9, 37-50

Malcolm, N. (1999) *Kosovo: a short history*. London: Macmillan

Mintz, S.W. (1974) The rural proletariat and the problem of rural proletarian consciousness. *Journal of Peasant Studies*, 1, 291-325

Rodman, H. (1971) *Lower-class families: the culture of poverty in Negro Trinidad*. New York: Oxford University Press

Schwander-Sievers, S. (1999) Humiliation and reconciliation in Northern Albania: the logic of feuding in symbolic and diachronic perspective. In Elwert, G., Feuchtuang, S. and Neubert, D. (eds.), *Dynamics of violence: processes of escalation and de-escalation in violent group conflicts*. Berlin: Duncher and Hunsblot

Senechal, M. (1997) *Long life to your children: a portrait of High Albania*. Amherst: University of Massachusetts Press

Smajlaj, L.P. (2001) *Kërkime mbi të vertertën*. Shkoder: Camaj Pipa

Strathem, M. (1990) Negative strategies in Melanesia. In R. Fardon (ed.). *Localising Strategies*. Edinburgh: Scottish Academic Press

Young, A. (2000) *Women who become men: Albanian sworn virgins*. Oxford: Berg

PRAYERS AND HEALING

Armando Favazza, M.D., M.Ph

Department of Psychiatry
University of Missouri-Columbia
U.S.A.

Prayer has many reasons but the Christian tradition that comes directly from the New Testament often emphasizes asking God for something. Paul states it is kosher to make all sorts of requests: "Be anxious for nothing, but in everything by prayer and supplication, let your requests be known to God " (Phil. 4:6). Among the most common requests are those for self-healing and the healing of others. Let's suppose that God-fearing, church-going, hard-working, devout parents pray in Jesus' name for the recovery of their child who is dying of leukemia. What is God supposed to do? The scriptures say, "Whatever things you ask in prayer, believing, you will receive" (Matt. 21:22); "Ask, and it will be given to you" (Luke 11:9); "Whatever you ask the Father in My name He will give you" (John 16:23).

It would seem that God is obligated to save the child but, more likely than not, the child will die. One could argue that God can't be expected to honor frivolous requests: "Lord, please don't let the Dodgers leave Brooklyn" (I tried this one as a child), or "Lord, please let me win the super-lottery" (I tried this one as an adult). But the life of a child hardly seems frivolous. Maybe the parents really didn't have enough faith or say the right words or pray long enough? Malarkey! These are heartless rationalizations. Fortunately for believers the Bible comes to the rescue because there is another passage (there always is another passage if you search diligently enough) that explains things. When Jesus prayed in the garden of Gethsemane prior to his betrayal and capture, he said: "Father, all things are possible for you. Take this cup away from me, nevertheless, not what I will, but what you will." No one clearly understands what the cup is. It's a red herring; the meat's in the last phrase. God's will takes precedence over a person's will, even if that person is Jesus.

Whatever will be, will be, because whatever happens is God's will, a.k.a. divine providence. Should the dying child recover "miraculously," one can't suppose that the parents' prayers had anything to do with it. Miracles are a human convention and really are exclamations of wonderment at unexpected changes in the course of events. From a providential perspective what happens is what is supposed to happen and cannot be unexpected. Jesus couldn't change God's mind, so what chance has a mere mortal? If you ask, the Gospels notwithstanding, you won't necessarily receive unless God already planned for you to receive. But Jesus promised, you might argue. That's between you and him, I would answer.

Would our hypothetical, devout parents have had better luck by taking their sick child to a faith healer? Even the most narcissistic healers do not claim to be gods, at least not publicly, but rather claim to have special spiritual "gifts" that signify an ability to intercede with God or, things get

a little murky here, to tap into God's will. MacNutt, who at least tries to discuss the matter seriously, distinguishes between an ordinary Christian's prayer of petition and the gifted healer's prayer of command. The former involves speaking to God while the latter "already knows in some mysterious way the mind of God, and so can speak in his person ... Be healed. Amen. I see it being done ... It is as if the person praying were standing with God and speaking for him." Even if we assume that some healers actually do speak for God, they cannot assume God's power to heal, just as a press secretary can speak for the President but cannot assume presidential authority. The special connections of faith healers are either imaginary or gossamer things. The Christian God is not a puppet. Maybe the healers reflect God's will but so can anyone. It's really quite simple: whatever happens must be part of God's plan.

What about those occasions when a disease process actually is changed following prayers for healing? A rational view would be that the timing of the prayer and of the disease change is coincidental. Not all diseases are progressive. In some, such as epilepsy, migraines, gastric ulcers, multiple sclerosis, and manic depressive illness, symptoms may remit for extended periods of time as the disease process become quiescent. Also, medicine has always recognized the rare spontaneous remission of some diseases, especially cancers. In fact, fourteenth century Saint Peregrine is associated with cancer regression; the cancer in his leg bones supposedly regressed following his prayers and dream of a cure. He was spared an amputation and lived for sixty more years. Spontaneous cures of biological lesions do occur, however, both with and without prayer. Mental illnesses also often get better with or without prayer although it is difficult to quantify or measure "lesions" in these cases.

Demoralized, sick persons who psychologically give up may accelerate their moment of death but participation in a prayer-healing ceremony and prayers for healing foster hope and positive feelings that may help persons feel better. This in turn may energize a sick person's natural recuperative powers, perhaps by affecting the immune system or by increasing motivation to participate in a rehabilitation program. Prayers may help but not necessarily through a supernatural process. The only way to disprove the previous statement is to demonstrate that prayers can produce results when the sick person being prayed for has absolutely no knowledge of the event. Even those people who associate with the sick person must be kept in the dark too because they might act in a hopeful manner and influence the sick person's psyche. Such an experiment must also clarify if a total cure is the desired result, or perhaps a temporary improvement will do. "Healing" is a very ambiguous term that ranges from slam-dunk dramatic reversals of illness to a drawn-out process of barely perceptible therapeutic gains.

A small number of prayer-at-a-distance studies have been carried out in which a group of prayed-for patients were compared to a similar group of control patients. The results generally have been negative with a few equivocals. Studies of 18 leukemic children and of 38 patients with either "chronic stationary or progressively deteriorating psychological or rheumatic disease" demonstrated no advantage either to the prayed-for or control groups. A poorly designed, pseudo-scientific-experiment popularized in the book Prayer Can Change Your Life studied 45 neurotic volunteers who were placed in either a psychotherapy group, a prayer for self-healing group, and a prayer therapy group. The prayer therapy group supposedly showed 72 percent improvement, the psychotherapy

group 65 percent; the self healing prayer group was a washout. Despite the impossibility of sorting out what variables were doing what, the experimenters could only claim a 7 percent advantage to the prayer therapy group. That's not very much to crow about.

Perhaps the best known study, published in 1988 by Byrd, compared a control group (201 patients) with an experimental group (192 patients) who were prayed for by born-again Christians. All the patients were on the coronary care unit of San Francisco General Hospital. A good hospital course was reported for 85 percent of the experimental group and for 73 percent of the controls, and a bad course for 14 percent of the experimental group and for 22 percent of the controls. In addition to the author's religious bias (in the acknowledgments he thanks God for responding to the prayers), there is no information about either the psychological characteristics of the subjects or the treatment practices of the various health care teams. Any of these factors could account for the 12 percent difference in the good course and the 8 percent difference in the bad course. In order for strict scientific requirements to be met no one involved with the study should have known which patients were in the control and prayed-for groups. However, the coordinator of this study not only knew the names of the patients in each group but also was responsible for keeping detailed records of all the patients. Additionally, the first version of the paper describing the study was returned with a request for a revision by the editor of the journal to which it had been submitted. The selection of criteria about what constituted good or bad hospital courses by the patients was reconstructed by the author after he knew which group each patient was in.

Some modern scientists attempt to displace the traditional prayer model with a rational-spiritual one. The new model, explicated in Larry Dossey's Healing Words, holds that prayers don't need an external God as an intermediary: "If God is present to some degree in all individuals, the Divine Factor in prayer is internal, not external to everyone." Further, since prayers are inherently infinite in both time and space, they don't go anywhere, and yet they are able to affect not only the present and the future, but also the past!

The underpinning of the new model relies on observations made by physicists working in the bizarre field of quantum theory. I use the word bizarre because quantum physics often overturns the basic concepts of reality on which most people rely. In the quantum world effects don't necessarily need to have a cause, atoms can have either a location or a motion but not both, an observer generates atomic reality and can even influence the past, and alternative worlds exist in parallel to one another. No, quantum physicists are not psychotic, they just seem to be. In any event, the relationship between the quantum world and the world of everyday experience is unclear at best.

Dossey's new model also takes into account a strange experimental literature demonstrating the effect of prayer on fungi, bacteria, yeast, moth larvae, plant seeds, vegetables, enzymes, cells in test tubes, and various physiological tests in rats. He concludes that open-ended invocations such as “Thy will be done" or "Let it be" are prayers that might get results. "They are more like an invitation for prayer's effect to manifest and show up."

I am reminded of Mesmer's displacement of demonic forces by his concept of animal magnetism two centuries ago. Mesmer, however, was able to produce "cures" in humans, while

Dossey can only cite "changes" in seeds, germs, and laboratory rats. Unless a spectacular breakthrough comes along (doubtful), Dossey will have to be content with an interesting book.

The major problems in trying to prove anything that involves spirituality or the supernatural are that "god" is a limitless concept, and the human mind-set determines the interpretation of results. Let us suppose that a well-done experiment demonstrates an overwhelmingly high cure rate in a prayed-for group of patients and a low cure rate for a control group. The believer will say that the facts speak for themselves and that prayer works, while the nonbeliever will say that there must be a rational, scientific explanation even if such an explanation is not readily apparent as yet. Reverse the results and the nonbeliever will stand on the facts, while the believer will say that the experiment was flawed, the prayers were not offered properly, God should not be tested, etc. Rational discourse cannot be applied to the supernatural, and vice versa.

The tension between the rationalist and the supernaturalist is nicely presented in Divine Healing and Cooperation Between Doctors and Clergy, a 1956 publication by the British Medical Association. The physician authors reported to the Archbishop's Commission on Divine Healing that, "We can find no evidence that there is any type of illness cured by 'spiritual healing' alone which could not have been cured by medical treatment." The conclusion of the Commission, however, stated that, "Scientific testing can be a valuable corrective of rash claims that healing, ordinary or extraordinary, has occurred and it may bring to light natural healing virtues in religious rites; but it is idle for the Church, or anyone else, to appeal to science to prove the reality of supernatural power or the truth of theology or metaphysics."

Priestly healing rituals and prayers do give some patients encouragement and may foster the will to be healed and to live. Hands-on "healing" can have a tremendous emotional impact and may be beneficial as long as patients are not dissuaded from seeking medical help or reduced to penury by unscrupulous "healers." While supernatural mechanisms can never be disproved (anything is possible in the realm of the supernatural), natural psychological mechanism are utilized in faith healing. Incantations have a venerable history going back to the early shamans. Done properly, even hocus-pocus and abracadabra can mobilize movements towards health. Done crassly, they can prove harmful.

Prayers at-a-distance for healing are not harmful but no experiment can be devised to prove their efficacy because there never can be a pure control group, e.g. it is impossible to rule out the facts that the prayed-for patient, family members, or friends may be offering their own prayers for healing.

RELIGIOUS BELIEFS, PRACTICE & COPING WITH MENTAL DISTRESS: A QUALITATIVE STUDY ACROSS ETHNIC GROUPS IN THE UK

Kamaldeep Bhui, Professor of Cultural Psychiatry & Epidemiology,
Barts & The London Medical School, Institute of Community Health Sciences, Queen Mary University of London.

Correspondance Professor Kamaldeep Bhui, Department of Psychiatry, Barts & The London, Queen Mary's School of Medicine & Dentistry, Institute of Community Health Sciences, Queen Mary University of London. Email: k.s.bhui@qmul.ac.uk. Tel: ++44 207 882 7842. Fax: ++44 207 882 7924

ABSTRACT

A British study included six ethnic used qualitative methods to explore coping, idioms of distress and health service use. Fieldwork was unclustered and took place in many areas of England. Forty-nine men and 67 women who had participated in the quantitative survey were interviewed using a semi-structured topic guide. 74 people were born in the UK or arrived in the UK before the age of 11, while 42 subjects came to the UK after aged 11. In addition people scoring above and below a threshold for defining a common mental disorder were both included. Interviews lasted between 30 minutes to two hours. All interviews were recorded and transcribed for analysis. Data were subjected to the *Framework* approach. The results show several coping strategies including stoicism, a positive outlook, survival thinking, hopefulness, drawing upon lived experience, normalising, rationalisation, avoidance, distraction/escapism, crying, responsibility for others and relaxation. Religious coping was particularly interesting with many similarities across religious groups but also different ways of relating to God and experiencing religious coping across ethnic groups. Specifically the analysis showed several key themes: religious as a way of coping, religion as a source of inner strength/peace, a relationship with God, the role of prayer and religious ceremony, religious attributions for difficulties and religious coping in secular lives. The findings suggest that a better understanding of religious coping may be a powerful source of preventing and moderating mental distress. The findings are discussed to illustrate the reflexive, mystical, and fluid nature in which religious coping moderates the relationship between mental health problems and mental distress. The relevance of religious coping for those proclaiming no religious orientation were also identified.

BACKGROUND & METHODS

A Department of Health study of six ethnic groups in the UK investigated rates of mental disorders in the community and undertook a focused qualitative study of coping, idioms of distress and health service use. Fieldwork was unclustered and took place in many areas of England. For the qualitative study, 49 men and 67 women who had participated in the quantitative survey were interviewed using a semi-structured topic guide. Respondents were aged between 25 and 50 years old, and interviewers were age and language matched for 7 different languages. Respondents were Christian (25), Muslim (40), Sikh (5), Hindu (6), Bhuddist (1), Rastafarian (1), with 37 subjects proclaiming no religious orientation. 74 people were born in the UK or arrived in the UK before the age of 11, while 42 subjects came to the UK after aged 11. In addition people scoring above and below a threshold for defining a common mental disorder

were both included. Interviews lasted between 30 minutes to two hours. All interviews were recorded and transcribed for analysis. Data were subjected to the *Framework* approach to analysis, a form of content analysis developed at the National Centre for Social Research in the UK. *Framework* uses a thematic approach to classify and interpret qualitative research data, treating every transcript in a systematic way within a common analytic framework. This makes the analytic method transparent, and enhances validity and reliability in interpreting the findings. The results show several coping strategies including stoicism, a positive outlook, survival thinking, hopefulness, drawing upon lived experience, normalising, rationalisation, avoidance, distraction/escapism, crying, responsibility for others and relaxation. Religious coping was particularly interesting with many similarities across religious groups but also different ways of relating to God and experiencing religious coping across ethnic groups. Specifically the analysis showed several key themes: religious as a way of coping, religion as a source of inner strength/peace, a relationship with God, the role of prayer and religious ceremony, religious attributions for difficulties and religious coping in secular lives. This paper firstly present empirical data that illustrates how these themes are important in coping with distress, and secondly shows, through case examples, the powerful effects of religious beliefs on coping with distress, and how these coping processes vary across ethnic groups. In particular differences between Caribbean origin black people, White British, Irish and Muslim South Asian subjects are compared and contrasted showing intriguing differences in the use of religious beliefs and practice. The findings are discussed to illustrate the reflexive, mystical, and fluid nature in which religious coping moderates the relationship between mental health problems and mental distress. The relevance of religious coping for those proclaiming no religious orientation were also identified. Coping strategies that differ across ethnic groups may explain variations in rates of common disorder across ethnic groups. This is the first national qualitative study investigating religious beliefs and coping in the UK.

RESULTS

Religious Issues & Coping

The sample was of Indian, Pakistani, Bangladeshi, African Caribbean, British and Irish people. Indian people practiced Islamic, Hindu and Sikh faiths. Respondents did not always speak of coping or resilience in terms of their religious faith. Of the three groups the Muslim subjects had more to say and offered a greater level of detail. Although this is crude measure, we looked at those who did not make any reference to religion in their response to coping with the difficulties: 7 out of 17 Indians, 7 out of 19 Pakistani, 5 out of 18 Bangladeshis, 3/18 Black Caribbean people, 11/20 English people and 15/24 Irish people. The English and Irish were the least likely to report religious ways of coping and the Black Caribbean groups was the most likely to show religious beliefs in coping. However as described below the Black Caribbean group's relationship with religion was not as certain or as immanent as the religious experience of the Indian, Pakistani and Bangladeshi groups. It was difficult to get a feel for distinctions between Hinduism, Sikhism and Islamic beliefs because so few people were of Hindu and Sikh backgrounds. All of the Pakistani, Bangladeshi and some of the India people were Muslim, so more information was available about this religious group. The following accounts introduce some of the respondents who capture the main types of beliefs, and coping expressed.

Immersion In Religious Beliefs As A Way Of Life

All the ethnic groups resorted to religious coping, however the Muslim religious groups appeared to be most absorbed in their religious views, these being indistinguishable from their way of life in general. The Muslim group talked of their surrender to God and that God determined all, it was a way of life. For example, a 37 year old Pakistani woman who'd been in the UK since the age of 6 said she prayed if she was sad or depressed or felt pressure. She felt that God controlled everything and was testing her. She was very isolated, had no friends, spoke little English and rarely went out. She perceived that everything was in God's hands. This was reiterated by other respondents (43 year old Pakistani man and 45 year old Pakistani man who had been in the UK since the ages of 5 and 11 respectively). Both felt that God would save them. Their view was that if God had given them trouble he would heal them. One of these men talked of how God controlled everything and gave us knowledge. He considered that medicine was subordinate to religion and that God gave the doctors their knowledge and so for Muslims, it seemed, all actions, events and experiences were subordinate to those of religious doctrine, but also a component part of it.

Changes In Self States And Distress

The Indian group, in particular the Hindu and Sikh people rather than the Muslim people, talked of inner strength, peace, calmness and meditation. African Caribbean people demonstrated a marked difference to the Indian, Pakistani and Bangladeshi groups in that they more often talked of religion, but talked of religion in a more flexible way, where they had choices. There was ambivalence, varying degrees of religious belief and ritual. Nonetheless religion was used to help them cope. They found strength, knowledge and wisdom guidance but also an *inner glow, peace* and *understanding*. It was surprising that the Irish group appeared not to be particularly religious or use religious beliefs particularly strongly in comparison with other groups. They appeared very similar to the British group of people. They sought *guidance, wisdom* and *knowledge* through their religion. There was a greater sense responsibility although they also found *calmness* in praying and religious involvement. There appeared in the African Caribbean, the British and Irish groups more of an equal relationship with God whereas that in the Indian, Pakistani and Bangladeshi peoples was much more deferential. The omnipotence and omnipresence of God was much more evident among the Indian, Pakistani, and Bangladeshi respondents.

Immersion Or Instrumental Use Of Religious Beliefs And Practice

There was contrast between the Muslim respondents and the Black Caribbean respondents. The latter drew on religion at the time of a problem and when things were going wrong. There appeared to be a more equal relationship with God rather than the deferential and all powerful perception expressed by Indian, Pakistani and especially the Bangladeshi people. One respondent (43 year old man, in the UK since the age of 13) talked to God saying "Lord this is hard I messed up it is not as if you are not providing for me". There appears to be more agency in the individual to make use of God's gifts rather than feel completely at his mercy. Nonetheless some respondents did talk of God being the only reason that they were alive, that they needed something greater than themselves to believe in. They also drew on religious beliefs and a relationship with God at difficult times, which were seen as trial periods to test faith. The belief was that through this they became stronger. They saw their relationship with god as being discrete and limited to particular times of difficulty, to overcome particular problems. Even if they expressed that they had an active faith

within which they lived, their use of their religious faith seemed more compartmentalised, as if religion was a separate component of their lives.

A 44 year old Caribbean woman, who had lived in the UK since the age of 15, said she didn't believe in God but in Jesus Christ. She was a single mother and felt that God had helped her in a difficult situation, when her daughter was unwell. She prayed regularly, did not consider herself to be a practicing Christian, but 'used her religion' to make sense of what was going on. This demonstrates use of religious beliefs and rules among people who do not consider that they are especially religious, and shows how religious instruction can become part of lay belief systems for coping without necessarily involving a formal commitment, or a total commitment, to religious worship. She found an experiences of *peace.* At the time of her daughter's illness, she felt God helped her overcome her fear. She listened to Christian radio, and that also made her feel *holy*. Her account suggests a changed experience of the self in response to relating to God and hearing religious radio, yet again she did not feel that she was compelled to be a part of the formal religious world or that she had strong religious beliefs.

Religious Attribution For Symptoms Of Distress

Some respondents understood their emotions, when volatile, to be the product of irreligious actions, or that religious actions help to diminish emotions. A 49 year old Muslim Pakistani man came to the UK at the age of 15. He talked of having anger and going to his mother for advice. He learnt to serve others and felt that he shouldn't be jealous or envious. These feeling and sentiments reflected, for him, the origin of his discontent and anger. If able to do these things [relinquish jealousy and envy and serve others], *God will reward you,* he said. He also talked of stress as something that needed to shared and when one realised how hard the stress was for another person, *God will be pleased*. His purpose for sharing stress was not based on notions of catharsis but more on an experience of another's stress and suffering, and an awareness of its overwhelming nature. This, he said, would please God.

A 47 year old Bangladeshi woman, who had been in the UK since the age of 29, said that if she missed prayers she did not feel good. She developed 'a temper' and she found that prayer kept this and other 'illness away from the mind'. Anger, aggression and loss of control, common accompaniments to mental disorders, were seen as a response to not praying enough. She also suggested that not talking about the problem kept the worry about it away from the mind. The 'mind was then clean' and then 'body would stay clean and strong'. This approach of distraction, and removal of the worries from the mind contrasts with what is expected in introspective psychotherapeutic practice.

Responsibility, God & The 'Right Way'

The Bangladeshi respondents were also Muslim however there was a slightly different flavour to their relationship with God and their use of religion as a coping strategy. They emphasised living 'in the right way' and a responsibility to God that included not 'making a problem'. If they have a difficulty then it must be acceptable to God and so they felt they had to accept life events and circumstances, rather than problemetise them.

Getting Perspective Through Prayer
A common theme among the Bangladeshi, and Muslim respondents, although present to a lesser extent among others, was distancing the self from bad feelings such as *greed*. Using religious words on tape was used as a source of *distancing* oneself from worries and *diverting one's mind*. There was a more accepting attitude and a desire to offer *service* to people, to offer *hospitality and respect*. Doing this led to *feeling good inside*. Prayer also did this and this led to having no worries. Prayer helped to *clear the mind* and see *what little problem* there was. This appeared to be a way of getting perspective on a problem. Reciting religious verses and also using prayer beads were other ways of inducing these states of no worry.

Acculturation And Challenge To Religious Beliefs
A few respondents talked of difficulties sustaining their faith, in the face of acculturative pressures. A 46 year old Pakistani woman who'd been in the UK since the age of 23 talked of having a Taveez which was an amulet in which religious prayers were contained. She said it stopped her from getting frightened and she felt pious and that God wouldn't hurt her. She expressed some difficulties in her marriage as her husband was not as religious as her, this leading to some conflict. Several other subjects also talked of uncertainty about the impact of living in this country on their religious beliefs and how their religious beliefs are challenged either through their children or within themselves.

Religion & Secular Lives
We planned to conduct separate analyses of the British and Irish groups. However, they appeared remarkably similar. They were conspicuous in that their accounts of their lives and their coping tended not to include religious beliefs in marked contrast to the groups discussed earlier. There were however some accounts, for example, that religion offered moral guidance and one respondent talked of being brought up as a Catholic but not believing in Catholicism but more in Christianity. He disagreed with some of the Catholic teachings and felt religion didn't offer moral teaching on how to live and what to do. Some people expressed having their religious beliefs and that they did pray, for example, at times of bereavement. Religion also offered 'spiritual relaxation', opened people up to 'feel calmer'. One respondent (Church of England) talked of the path being set out for them and they had to ride it out reflecting a similarity with the karmic expression found in the Indian accounts. Other English and Irish respondents talked of finding tremendous peace at a time of difficulty.

Non-attendance at Church did not hinder people's beliefs and use of religion as a way of coping. One particular respondent, a 32 year old British woman, talked of praying as the equivalent of mini-counselling. She didn't pray every night and prayed whether things were going well or badly. She felt God was looking after her and felt 'a warm glow' with it. She felt that religion and God helped her to take on responsibility for herself. This contrasts with the earlier accounts of the Bangladeshi Muslim group and the Pakistani Muslim group whereby responsibility was given up to God and one individual even talked of 'surrender of God'.

CONCLUSIONS

The findings suggest that a better understanding of religious coping may be a powerful source of preventing and moderating mental distress. Professional do not usually recognise the role of spiritual care in the management of mental distress. These and other research findings suggest much more attention, including research and clinical guidelines, need to be developed to support indigenous coping styles, and enhance spiritual coping where this mitigates crisis in response to mental distress.

ALTERED STATES OF CONSCIOUSNESS IN TRADITIONAL HEALING IN NEPAL

Dagmar Eigner

University of Vienna, Austria

University of Vienna
Porzellangasse 7B/6
Vienna A-1090
Austria
Tel/Fax: + 43-1-3109262
Email: dagmar.eigner@univie.ac.at

Shamans, mediums, and tantrics use various kinds of altered states of consciousness to make their cures as efficacious as possible. Through rhythmic singing, drumming, dancing, and shaking their bodies shamans induce a state of consciousness in themselves that enables them to travel to other places to find out more about the causes of the illness of a client or to negotiate with a spiritual being in order to save a patient's life or bring back lost vital energy that has been captured by that being (see, for example, Eliade 1954). In an altered state of consciousness deities or spirits also come on the head and shoulders of shamans to act through them and speak through their mouths in the course of healing rituals. If a person is possessed by an illness-causing spirit, and especially if the spirit has been sent by a witch, the shaman also tries to induce an altered state of consciousness in the patient to actualize the state of possession during the séance so that the illness-causing spirit can be asked what it wants, who has sent it, why the patient has been harmed, and what has to be done to solve the conflicts. The shaking of the body is not only a powerful technique to induce an altered state of consciousness but it is also seen as a sign that some spiritual being has come on a person. At the time of questioning the illness-causing spirit the shaman and the patient are sitting opposite to each other, both shaking their bodies. The shaman is connected with his/her tutelary deity or spirit and the patient with the illness-causing force (Eigner 2001).

In altered states of consciousness mediums get into contact with deities and at times they also speak and act through them. Usually mediums are called by female deities who then become the main source of power for their work. Mediums also question witches who are troubling clients, but they never deliberately induce altered states of consciousness in the patients.

Tantric healers work with mantras, magic formulae, and actions that belong to the specific mantras. They receive a formal education which takes several years and is based on the repetition of the mantras and practicing meditation in order to gain the ability to empower the mantras. They never become possessed but during their training period the have to encounter evil spirits in dangerous places and prove that they can master them (compare Dietrich 1998).

Giving an example of a medium's healing session I want to point out the implications and effects of different altered states of consciousness. The medium is a woman in her mid-fourties and was chosen to work as a healer by the Goddess Dakkshin Kali whose shrine is about twenty kilometers south of Kathmandu. It is a local form of the powerful Hindu Goddess Kali, who is also the tutelary deity of many Buddhist shamans and mediums. Dolma, the healer, belongs to the ethnic group of the Tamang, who are famous for the large number

of shamans among them, but because she has grown up in a village mainly inhabited by Newars (an ethnic group with a completely different language and social rules and organization, see Bista 1967) she has adopted many Newari customs. She says that she has not had any live teacher but people tell that she has (or has had) close contact to a Newari healer. The powerful female deities are considered to be mothers for the humans and so they and their mediums are called ma or mata, both terms meaning mother.

In the morning before Dolma starts her work she worships Dakkshin Kali and other deities, singing devotional songs, burning incense, lighting little oil lamps, and whispering mantras. By performing her morning rituals she gets into close contact with the spiritual powers that help her during the healing sessions. Tuesdays and Saturdays, which are regarded as very auspicious days for healing rituals, a large number of deities come over her and act and speak through her, which creates a very special atmosphere. Patients get the chance to experience the power of the deities in an immediate way and they can consult Dakkshin Kali who always appears first, being the tutelary deity of Dolma. Saturday is the day off in Nepal and many people use the opportunity and go to visit healers even if they are not sick, just to feel the divine atmosphere.

A video shows three different parts of a medium's healing session:
1) A standard treatment that is used for many ailments
2) The medium's tutelary deity talking to the clients
3) Another deity acting through the medium

Ad 1) The patient, a middle-aged woman, has pains in her body and sometimes feels drowsy, not being able to take part in the daily social life in her community. As it is not her first visit to the healer no divination is done. The treatment consists of whispering mantras, putting tiny amounts of purified and empowered ash on some parts of her body, blowing mantras over her body while the medium puts her hand on the patient's head, a kind of massage with the side of the medium's hand on the head, shoulders, arms, legs, and the back of the patient, and empowering water with mantras that the patient is given to drink afterwards. All this is done to drive away the illness and the sufferings of the patient. At the end of the treatment the patient bows down to the knees of the medium sitting on a thin cushion. These little treatments are done three or four times on consecutive days.

Ad 2) Dakkshin Kali, the tutelary deity of the medium, is speaking through the her mouth, because some clients wanted to consult the goddess herself. The patient, a young man, is mentally disturbed and has problems with a member of the extended family. After his daily little treatment that was done some time earlier on the same day I had a brief conversation with him and his wife:

Dagmar: What are you suffering from?
Patient: It feels like something is pulling from inside and I am very uncomfortable. My heart moves fast, there is dizziness in my head and I feel as if I would fall down the next moment.
Dagmar: What is the reason for this?
Patient: She (the healer) said that someone has done harm to me and has sent the ghost of the cremation ground to me to cause troubles. I have already done rituals nine or ten times to send back the ghost but the person who has caused my suffering has been adding harm to me. After the treatment here I am fine but when I go back home I feel bad again.
Dagmar: Since when have you been feeling ill?
Patient: Since one and a half years. I come here for treatment every day.

Dagmar: Do you know who has caused the troubles?
Patient: No. Mata knows it but she has not told it to us. Now, after the treatment I feel better. I am fine for the rest of the day but next morning it starts again.
Dagmar: Did you see a doctor?
Patient: Yes, I also went to see Dr. Upendra (a neurologist). He says there is nothing wrong with me.
Dagmar (asking the patient's wife): How do you feel about your husband's problems?
Patient's wife: We feel bad, all the family feels bad.
Dagmar: What exactly happens to him?
Patient's wife: His face becomes serious. Now, he is feeling lighter, so his face is bright. But when it starts again his face becomes yellow and his eyes look as if he had taken drugs and he feels drowsy. We really feel bad about this, and it happens every day. We do not know when and where it starts, so wherever he goes he needs a friend to accompany him, who is there with him in case something happens. Because of Mata he is still alive up to now.
Dagmar: What does she say that has to be done?
Patient's wife: We depend on her. Now we don't go to doctors anymore. Mata will cure him. We trust her, we believe in God.
Dagmar: Do you know who has caused the problems?
Patient's wife: When we see the people in our (extended) family they all look nice, but who knows what they have in mind? She said it is someone among our own relatives. Mata has not told us who it is, because it would create more anger.

While the goddess is speaking to the clients the medium's helper is burning incense in front of her body. The helper also makes sure that the people in the room behave in the right way and introduces the clients who want to consult the goddess. In some cases the goddess does not give a final advice to the clients but refers them to "her child", the medium, who knows about everything and will continue the divination and do the treatment. When the mentally disturbed young man had his turn he put some rice kernels into the right hand of the healer and then the following conversation took place:

Patient: I have done everything that you have told me to do.
Goddess: What shall we do? Whatever was needed to do we have already done. When you come to my place you feel light and when you go back to your house you feel the same as before.
Patient: You have told me that if I go and stay in the upper house (extended families sometimes have separate houses in the same compound) I will feel better, but when I went to stay there nothing changed.
Goddess: Wherever you stay, in the upper house or in the lower house, there will be communication with your family members (including the one who has harmed the patient), my child, what to do?
Patient: Mata, please do something so that she cannot harm me anymore!
Goddess: Have you done everything I have told you to do?
Patient: Yes, Mata, I have done whatever you told me to do.
Goddess: But look, my child, you have not brought three things that I have told you to bring.
Patient: How to bring these three things, Mata? Please, bring them!
Goddess: That person has harmed you out of jealousy; she has done several things to harm you.
Patient: Mata, please do something so that that person will not be able to hurt me anymore.
Goddess: We can do that, but that person has sent you the ghost of the cremation ground. In your dreams you see this ghost; is it true or not, my child?

Patient: Yes, it is true. Now, what shall we do, Mata?
Goddess: Go to Manakamana, she is my sister (Manakamana is a famous pilgrimage place where there is a shrine of another female deity who is considered to be a sister of Dakkshinkali, the tutelary deity of the medium).
Patient: I have promised to go there, but I have not done it yet.
Goddess: Go there, go there as soon as possible!
Patient: But it is difficult to go there (because he is not feeling good).
Goddess: Bring my child (the medium) along. If anything happens, we are there to look after you. Don't be afraid! I guarantee that nothing will happen to you.

At some times during this conversation the goddess shouts to the patient and also pull his hair. Goddesses are not always gentle and they ask obedience from the patients. If the young man does whatever he is asked to do, he has the guarantee that he will get well.

Ad 3) After the tutelary deity of the medium has gone several other deities act through her and say their names. In the video the last one, Bagh Bhairab, the Tiger God, can be seen and heard. He growls, shoes his teeth, and the facial expression of the medium is fierce. The Tiger God asks for some burning wicks to eat, and this is also the sign of departure. It is the end of the possession scenes. The medium only takes a few minutes to get back into the state of consciousness in which she is connected with her tutelary deity who gives her the power to heal, but neither Dakkshin Kali nor any other deity will speak or act through her until the end of the healing session.

Dolma had never seen herself on a video screen and she was very curious to observe how she would look in a state of possession. While watching the video of the healing session she made the following remarks:
"I am surprised. People used to say that deities come on me and I wanted to see what it looks like. …
That is not me. …
This is the same as the Goddess Kali. My appearance is the same as Kali's.
Nobody will say that is me. That is not me. …
People used to say several things to me. Now I am experiencing it. Some said that they had seen different faces but I have never believed them. Now it is becoming clear to me. …
Now I am very surprised. Do you see this face (her own at the time of watching the video) and that face (that is shown on the television screen) being the same? …
Wherever I go all my friends and other people call me mata. They take care so that they don't touch me with their feet (what would be an insult to the goddess). They sit separately. And I tell them: 'Don't call me Mata, I feel awkward. When I sit at my guru's place, then it is alright, but, please, don't call me Mata now.' I tell this to my friends."

Dolma differentiates between her everyday life and her life as a healer. While sitting on her special seat she should be treated like a deity, but when she has left that place and goes about her activities in everyday life she is an ordinary person like others. There are, however, some rules that she has to obey since Dakkshin Kali has come to her for the first time: she should not eat pork, chicken meat or chicken eggs (when I was served snacks, ducks' eggs were used), she should not eat from another person's plate or food that has been prepared by an impure person (to make sure that this does not happen she only eats food prepared by her servant girl or by one of her disciples or former disciples), and she has to take a bath and wash her hair every morning. Otherwise she leads a normal life as a mother and grandmother, and is engaged in political activities .

Still watching the video of the healing session I asked some questions about the meaning of actions and her feelings:
Dagmar: Why is incense burnt when the deities come?
Dolma: To make them happy.
Dagmar: When you are shaking, does it mean that a deity is coming on you?
Dolma: Yes. If I want to shake now, I cannot do it. … My voice is different. Look at my eyes!
Dagmar (asking Rajani, Dolma's assistant): You have seen Mata like this many times, how do you feel now?
Rajani: Not any different.
Dagmar (addressing Dolma): What do you feel at the time when a deity comes on you?
Dolma: I remember until my right hand is shaking. When a deity comes, then the right side will shake, but when something evil comes, the left side will shake. At the time of a deity coming I only remember until my right hand shakes.
Dagmar: What happens when the deity leaves?
Dolma: We don't know what happens, but after that I feel as if I am waking up from a dream.
Dagmar: What do you feel now when you see a deity coming on you?
Dolma: I feel scared.

Several people mentioned that they felt scared when the deities appeared. It is probably the awe that strikes people in the presence of the sacred. When healers work with the power of deities and let them act and speak through their own bodies, the patients often feel that they are taken care of by the healers and the deities. The patient's sorrows and their sufferings are taken from their shoulders by the divine forces.

Listening to Dolma's comments on her healing sessions it becomes obvious that some changes of the consciousness of her self have taken place (compare Scharfetter 1996: 72ff.). Especially the border of her self has become very open so that she can unite with spiritual beings. But also the activity of her self is changing: she is no longer the determining force of the actions, and her everyday experiences give way to something that she cannot put into words, something that has no clear image in an everyday state of consciousness so that she says she does not remember. Waking up from a dream means coming back from an alternate reality. While watching the videos she sees herself as Dolma, the person who acts in an everyday reality, but she also sees something else, something that is scary to her when she is not sitting on the deity's seat. In modern Western psychotherapy we talk about building a sense of "we": the patient and the therapist who is there for the patient and supports her/him. In Dolma's practice the "we" consists of three parts: the patient, the healer, and the deity who gives a special power to the healing process in which the patient is embedded and can feel secure. Even if for some reason the healer cannot manage, the deity for sure will make the patient well.

When deities act and speak through the medium the performance (see, for example, Laderman and Roseman 1996) reaches its height with an overload of sensory stimulation: patients see, hear, smell, and touch the deity who is incorporated by the medium. The bodily experience may have an immediate effect – as it is suggested by the theory of the "performance of healing". Sensory input, however, is immediately processed in the central nervous system, connecting sensory stimuli with memories, wishes, hopes, social and cultural meanings. When a client "perceives" something, he/she already knows what it is and what it means. It may be a private, individual interpretation or a culturally shared interpretation. Thus, the performance is a bodily and a cognitive experience as well. Even though the deities do not do

any treatment themselves they prepare the ground for the medium's healing actions. The patients feel the presence of the divine and they know that the deities will take care of them if they show due respect and devotion. And through devotion they get closer to the deity and its power – like the healers themselves.

Viktor Frankl (19) has coined the term "spiritual persona" that integrates the psyche and the soma and thereby makes a person a whole unity. A whole person is healthy and Frankl considered the "spiritual persona" as some healthy core in the patient. The deities and their mediums also address a healthy core when they give their orders to the patients. The deities are there to alleviate the patient's sufferings, but they also ask them certain things to do. Even if the patients are weak and in pain, the sacral-psychic-bodily treatments makes them feel better and the devotion to the deities that connects them with a sacral-vital energy makes them stronger. An intricate pattern of divine, human, cognitive, and bodily forces lays the way to health.

REFERENCES:

Bista, Dor Bahadur (1967): People of Nepal. Kathmandu: Ratna Pustak Bhandar.
Dietrich, Angela (1998): Tantric Healing in the Kathmandu Valley. Delhi: Book Faith India.
Eigner, Dagmar (2001): Ritual, Drama, Imagination: Schamanische Therapie in Zentralnepal. Wien: Wiener Universitätsverlag.
Eliade, Mircea (1957): Schamanismus und archaische Ekstasetechnik. Zürich: Rascher.
Frankl, Viktor
Laderman, Carol and Roseman, Marina (1996): The Performance of Healing.
Scharfetter, Christian (the presence of the divine has an immediate effect and prepares the additional treatment that is done afterwards by the healer)

Author Index

A B C D E F G H I J K L M
N O P Q R S T U V W X Y Z