Annual Meeting of the Society for the Study of Psychiatry & Culture – Advanced Study Institute in Cultural Psychiatry
Division of Social & Transcultural Psychiatry, McGill University

Rethinking Cultural Competence from International Perspectives

McGill

SSPC
Society for the Study of Psychiatry and Culture

www.psychiatryandculture.org

Conference & Workshop
April 29 - May 1, 2010
Holiday Inn Midtown, Montreal

SOCIETY FOR THE STUDY OF PSYCHIATRY AND CULTURE

Annual Meeting

with the

ADVANCED STUDY INSTITUTE

DIVISION OF SOCIAL & TRANSCULTURAL PSYCHIATRY
MCGILL UNIVERSITY

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Montréal, Québec

Welcome Message

Dear Colleagues,

Welcome to Montreal and the annual meeting of the Society for the Study of Psychiatry and Culture. We last held the meeting here in 2003 and it was a great success. This time, the SSPC Meeting has been organized in conjunction with the annual Advanced Study Institute in Cultural Psychiatry of the McGill Division of Social and Transcultural Psychiatry of the Department of Psychiatry, McGill University and is followed by the McGill Summer Program in Social and Cultural Psychiatry, now in its 16th year.

The theme of both the McGill ASI and the SSPC Meeting is Rethinking Cultural Competence from International Perspectives and most of the presentations speak to this broad issue. We have an exciting mix of colleagues from around the world and look forward to the warm conviviality and spirited exchange that make the SSPC meetings a unique event.

Once again, on behalf of all of the organizers and staff, we welcome you to Montreal and hope you find the conference rich and stimulating.

James Boehnlein

Laurence J. Kirmayer

Elizabeth Kramer

2010 Annual Meeting Organizing Committee

Jim Boehnlein
Laurence J. Kirmayer
Elizabeth Kramer

2010 Annual Meeting Scientific Program Committee

Jim Boehnlein
Danielle Groleau
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G. Eric Jarvis
Laurence J. Kirmayer
Elizabeth Kramer
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Division of Social & Transcultural Psychiatry Staff

Rachel Verkade
Katya Petrov
Sudeep Chaklanabis, MD

Acknowledgements

Many thanks to all those who helped bring this program to fruition. The Scientific Program Committee reviewed all the abstracts, structured the program and reviewed applications for the John Spiegel Fellowship Award. Joan Koss reviewed the Charles Hughes Fellowship applications, Rachel Verkade did most of the "leg work" and took care of details that got us to this point, Katya Petrov edited and produced the program book, and Zima Khanna, SSPC webmaster and administrative assistant, kept us organized and functioning.

About the SSPC

The Society for the Study of Psychiatry and Culture (SSPC) is an interdisciplinary organization devoted to furthering research, clinical care and education in cultural *aspects* of mental health and illness.

The SSPC promotes integration of culture in psychiatric theory and practice. Areas of interest include: (1) research on social and cultural dimensions of mental illness, comparative studies of psychopathology, and the cultural contexts of psychiatric practice; (2) innovative approaches to culture in clinical practice; and (3) training of psychiatrists, other health professionals and social scientists.

The SSPC aims to promote cultural psychiatry in North American professional groups and to collaborate with national and international organizations in the development of policy and practice. The SSPC also aims to foster exchange among clinicians and researchers engaged in cultural psychiatry, other medical and allied health professionals, and social scientists.

Continuing Medical Education

This event is approved for up to 20.25 credits by the Centre for Continuing Health Professional Education (CCHPE). The Centre for CCHPE, Faculty of Medicine, McGill University is fully accredited by the Committee on Accreditation of Canadian Medical Schools and through the (CACMS) is accredited to award AMA PRA category 1 credits.

This event is an Accredited Group Learning Activity as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada.

Through a reciprocal agreement between the American Medical Association and the Royal College of Physicians and Surgeons of Canada, the Centre for CCHPE, Faculty of Medicine, McGill University designates this activity for AMA PRA Category 1 credit(s) up to the maximum number of credit hours noted above.

Each physician should claim only those hours of credit that he/she actually spent at the educational activity.

Overall Learning Objectives for the Conference

1. To review and discuss the relevance of culture in global mental health.
2. To examine strategies for addressing cultural diversity in mental health care.
3. To analyze and critique cultural competence in individual countries and from a global perspective.
4. To critically assess notions of culture and cultural adaptation in education and clinical care.

Participants will gain knowledge of:

1. Meanings and interpretations of cultural competence;
2. How cultural competence is incorporated into clinical care in various countries;
3. How to identify the differences among various countries and the factors that influence them;
4. To know how to assess what works best and what doesn't work at all in different settings, and to be able to develop and implement plans that have potential for success.

SSPC Fellowship Awards to Trainees

CHARLES HUGHES FELLOWSHIP IN CULTURAL PSYCHIATRY: JESSICA DERE

This award is presented to a graduate student who has an interest in and commitment to research in cultural aspects of mental health and illness.

Jessica Dere, M.Sc. holds a master's degree in cultural psychiatry from McGill University, and is currently a doctoral candidate in clinical psychology at Concordia University in Montreal.

JOHN P. SPIEGEL FELLOWSHIP IN CULTURAL PSYCHIATRY: DR. YAVAR MOGHIMI

This award is presented to a resident or fellow who has an interest in and commitment to cultural psychiatry.

Yavar Moghimi, MD, a graduate of the George Washington University School of Medicine, is a third year psychiatry resident at George Washington University in Washington, DC.

SSPC Awards to Professionals Who Have Made Outstanding Contributions to the Field of Cultural Psychiatry

LIFETIME ACHIEVEMENT AWARD: DR. LAURENCE KIRMAYER

Laurence Kirmayer, MD, is James McGill Professor and Director, Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University and Editor-in-Chief of *Transcultural Psychiatry*, a quarterly scientific journal published by Sage (UK). In addition, he directs the Culture and Mental Health Research Unit in the Department of Psychiatry at the Jewish General Hospital in Montreal, where he conducts research on mental health services for immigrants and refugees, psychiatry in primary care, the mental health of Aboriginal peoples in Canada, and the anthropology of psychiatry. His current projects include studies on resilience among indigenous peoples, the usefulness of the cultural formulation in psychiatric consultation, and a cross-national comparative study of models of mental health care for multicultural societies. His past research includes studies on the development and evaluation of a cultural consultation service in mental health, pathways and barriers to mental health care for immigrants, somatization in primary care, the comparative study of psychiatry in Canada and Japan, cultural concepts of mental health and illness in Inuit communities, risk and protective factors for suicide among Inuit youth in Nunavik (Northern Québec), and the role of metaphor in psychiatric theory and practice. He founded and directs the annual Summer Program in Social and Cultural Psychiatry at McGill. He also is founder and Co-Director of the National Network for Aboriginal Mental Health Research funded by the Canadian Institutes for Health Research. He co-edited the volumes *Current Concepts of Somatization* (American Psychiatric Press, 1991),

Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives (Cambridge University Press, 2007), *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada* (University of British Columbia Press, 2008) and *Encountering the Other: The Practice of Cultural Consultation* (Springer SBM).

CREATIVE SCHOLARSHIP AWARD: DR. RICHARD MOLLICA

Richard F. Mollica**,** M.D., M.A.R., is Director of the Harvard Program in Refugee Trauma (HPRT) of Massachusetts General Hospital and Harvard Medical School. HPRT conducts training, policy and research activities for traumatized populations around the world. HPRT's screening instruments are considered a gold standard in the field and have been translated into more than 30 languages. Its scientific work has helped place mental health issues at the center of the recovery of post-conflict societies. Over the past 30 years, Dr. Mollica and his team have cared for more than 10,000 survivors of extreme violence worldwide.

Dr. Mollica received his medical degree from the University of New Mexico and completed his Psychiatric residency at Yale Medical School. While at Yale he also trained in epidemiology and received a philosophy degree from the Divinity School. In 1981, he co-founded the Indochinese Psychiatry Clinic (IPC). Over the past two decades HPRT and IPC have pioneered the mental health care of survivors of mass violence and torture. HPRT/IPC's clinical model has been replicated throughout the world.

The SSPC recognizes Dr. Mollica for his book**,** *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World* (Vanderbilt University Press, 2006), in which he celebrates "the capacity of persons to recover from violent events and to engage in self-healing." His empowering message is that the invisible wounds left by violence are not intractable, that people can and will persevere. In October 2010, he will receive the APA Kun-Po Soo Award acknowledging his contributions toward integrating Asian culture into psychiatry.

Program

APRIL 29, THURSDAY AM

7:15 – 8:30 Program Committee Meeting

8:30 – 9:00
Welcome remarks: Jim Boehnlein and Laurence J. Kirmayer

Session 1. 9:00 – 12:30
Critiquing the Concepts of Cultural Competence

9:00 – 9:30
Introduction: Rethinking cultural competence
Laurence J. Kirmayer

9:30 – 10:00
Revisioning the concept of culture in psychiatry: A critique
Joan Koss-Chioino

10:00 – 10:30 Break

10:30 – 11:00
Rethinking cultural competence in indigenous community treatment settings:
Inflections of tradition, reclamation, and post-coloniality
Joseph P. Gone

11:00 – 11:30
Reframing cultural competence as a multi-level health equity intervention
Kwame McKenzie

11:30 – 12:30
Discussants: *Sushrut Jadhav, Cécile Rousseau*
Panel Discussion: (Chair: Kirmayer)

12:30 – 2:00 Lunch
Charles Hughes Award Presentation
Unpacking cultural differences in alexithymia:
The role of cultural values among Euro-Canadian and Chinese-Canadian students
Jessica Dere

APRIL 29, THURSDAY PM

Session 2. 2:00 – 5:30 PM

International Perspectives on Cultural Competence
Chair: *Mitchell Weiss*

2:00 – 2:20
Psychotherapy and migration:
Cultural competence as the new paradigm in mental health care in France
Rachid Bennegadi

2:20 – 2:40
Operationalization of cultural competence in Geneva, Switzerland:
Research, training, intervention
Patricia Hudelson

2:40 – 3:00
Clinical application of cultural formulation in Stockholm
Marco Scarpinatti Rosso

3:00 – 3:30 Break

3:30 – 3:50
Why is 'cultural competency' not a popular term in psychiatry in India?
Sumeet Jain & Sushrut Jadhav

3:50 – 4:10
Clinical subcultures and competent treatment of neurasthenia spectrum disorders in four clinics of Pune, India
Mitchell Weiss, Vasudeo Paralikar & Mohan Agashe

4:10 – 4:30
Cultural competence in the context of evidence-based medicine
Rob Whitley

4:30 – 5:30
Discussants: *Edvard Hauff*, *Frederick Hickling*
Panel Discussion (Chair: Mitchell Weiss)

APRIL 29, THURSDAY EVENING

5:30 – 7:30 Reception for the SSPC/ASI

Poster Session

The Multicultural Mental Health Resource Centre
Abdelhamid Afana, Aidan Jeffery, Eugene Raikhel & Laurence J. Kirmayer

Acculturation and folk explanations of depression among Chinese-Canadians
Lauren M. Ban, Jessica Dere, Carl F. Falk, Steven J. Heine, Andrew G. Ryder

Integrative health in psychiatry
Lorin Boynton

Roots of Resilience
Laurence J. Kirmayer

The National Network for Aboriginal Mental Health Research
Colette Isaac & Laurence J. Kirmayer

Psychiatric subjectivity and cultural resistance:
Experience and explanations of schizophrenia in China
Zhiying Ma

The treatment of first episode psychosis in Chennai and Montreal
Alessandra Miklavcic, Srividya Iyer & Elsje van der Ven

Assessing emotional and behavioral symptoms in relation to school absenteeism in refugee and immigrant youth
Tonje Persson, Marie-Pier Dumas & Naomi Grenier

Needs assessment and development of cultural competency resources in an academic medical center department of psychiatry
Felicia Wong

7:30 – 9:00 Film

Shadows and Illuminations – Producer and Director: Robert Lemelson
Chair: *Laurence J. Kirmayer*
Discussant: Janis Jenkins

APRIL 30, FRIDAY AM

7:15 – 8:30 Education/Training Committee

Session 3. 8:30 – 10:30 / Concurrent Sessions

3A. *Cultural Competence in Global Health*	**3B. *Culturally Competent Interventions***
Chair: *Duncan Pedersen*	Chair: *Jaswant Guzder*
8:30 – 8:50 Globalization and substance use and abuse among Samoan adolescents *Harold Odden*	8:30 – 8:50 Mutual creative space: A translation of cultural competence into an action-model in mental health *Gadi BenEzer*
8:50 – 9:10 Searching for the evidence: Emerging dilemmas of humanitarian interventions in complex emergencies *Hanna Kienzler & Duncan Pedersen*	8:50 – 9:10 Adapting and transforming services and interventions across cultures: Identifying cultural services preferences *Les Whitbeck*
9:10 – 9:30 Enforcing cultural competence: Domestic abuse in a South India village *Helen Ullrich*	9:10 – 9:30 Cultural competence in medicine *Jon Streltzer*
9:30 – 9:50 Cultural psychiatry and intractable conflicts *Steven Wolin*	9:30 – 9:50 The cultural context of methods, practices and policies *Luis Vargas*
9:50 – 10:10 Discussion	9:50 – 10:10 Discussion

10:10 – 10:40 Break

Session 4. 10:40 – 12:30
The Future of Cultural Competence I: Training
Chair*: Cécile Rousseau*

10:40 – 11:00
Accreditation and training in cultural competence
Francis Lu

11:00 – 11:45
The resident perspective: Pros and cons of cultural linguistic matching patient to provider
Felicia Wong, Daniel Fallon & Jacqueline Smith

11:45 – 12:30
Transcultural psychiatry discussion groups: A space for reflection, inquiry, and sharing food
Michaela Beder, Layla Dabby, Alpna Munshi, Priya Raju & Lori Wasserman

12:30 – 2 PM Lunch: Resident Roundtable

APRIL 30, FRIDAY PM

Session 5. 2:00 – 5:00 PM

The Future of Cultural Competence II: Policy and Practice
Chair: *James Boehnlein*

2:00 – 2:30
Cultural Formulation Scale: A tool for the improvement of cultural competence.
Renato Alarcon

2:30 – 3:00
The cultural formulation in DSM-V
Roberto Lewis-Fernandez

3:00 – 3:30
Incorporating diverse needs and strengths into the development of a mental health strategy for Canada
Farah Mawani

3:30 – 4:30
Roundtable discussion
Chair: *Laurence J. Kirmayer*

4:30 – 6:00 PM
Workshop: (Chair: Kenneth Fung)
Developing a cultural competence plan for health care organizations
Kenneth Fung, Ted Lo, Lisa Andermann & Rani Srivastava

4:30 – 6:30 PM SSPC Board Meeting

7:30 PM
Dinner at the Alep Restaurant
199, rue Jean-Talon E (corner Ave. de Gaspé)
Montreal, Québec, H2R 1S8
Reservations are now closed.

MAY 1, SATURDAY AM

7:15 – 8:30 Communications/Public Relations and Membership Committee Meetings

8:30 – 9:00 SSPC Business Meeting

Session 6. 9:00 – 10:30 / Concurrent Sessions	
6A. ***Free Paper Session: Dilemmas of Diagnosis*** Chair: *S. Fernando* 9:00 – 9:20 Use of cultural consultation to resolve uncertainty in the diagnosis of psychosis in African immigrant patients *Ademola Adeponle, Laurence J. Kirmayer, Brett D.Thombs & Danielle Groleau* 9:20 – 9:40 Redefining personality disorder: A Jamaican perspective *Frederick Hickling & Vanessa Paisley* 9:40 – 10:00 Racism, depression and cultural competence in the diagnosis of African Americans *Larry Merkel* 10:00 – 10:20 Differential diagnosis between spiritual experiences and mental disorders *Alexander Moreira-Almeida* 10:20 – 10:30 Discussion	**6B.** ***Symposium: Cultural competence in Clinical Practice: Pitfalls and Drifts*** Chair: *C. Rousseau* 9:00 – 9:20 Cultural expertise in the service of racism: A reflection on the counter-therapeutic risks of the cultural competence model *Marie-Eve Cotton* 9:20 – 9:40 Language as a journey in clinical space: Moving towards cultural sensitivity in transcultural psychiatry *Sylvaine de Plaen* 9:40 – 10:00 Blinded by one's own expertise: Ethic matching and transitional spaces *Constantin Tranulis* 10:00 – 10:20 Discussant: C. Rousseau 10:20 – 10:30 Discussion
10:30 – 11:00 Break	

Session 7. 11 – 12:30 / Concurrent Sessions	
7A. ***Free Paper Session: Clinical Practice*** Chair: *Frances Lu*	**7B.** ***Free Paper Session*** Chair: *S. Jadhav*
11:00 – 11:20 The meaning of physical symptoms for patients and mental health clinicians *Nicholas Carson*	11:00 – 11:20 Cultural distance and treatment negotiation: Study from Sundarban Delta, India *Arabinda Chowdury*
11:20 – 11:40 Impact of the use of the DSM-IV outline for cultural formulation on the dynamics of multidisciplinary case conferences in mental health *Nathalie Dinh*	11:20 – 11:40 Evolving understanding of cultural sensitivity in the Christianization of India *John M. de Figueiredo*
11:40 – 12:00 Where the exception becomes the norm — At the juncture of culture, trauma and psychiatry: Applying Agamben's "state of exception" to trauma studies and cultural competence *Vincenzo Di Nicola*	11:40 – 12:00 The application of cultural psychiatry to office practice *Houshang Hamadani*
12:00 – 12:30 Discussion	12:00 – 12:30 Discussion

12:30 – 2:00 PM
Lunch: John Spiegel Award Presentation
Fetishism, inalienability, and material culture: A case study in compulsive hoarding
Yavar Moghimi

MAY 1, SATURDAY PM

Session 8. 2 – 5 PM / Concurrent Sessions	
8A. ***Symposium: Culture & PTSD*** Chair: *D. Hinton*	**8B.** ***Free Papers*** Chair: *G. Eric Jarvis*
2:00 – 2:20 Endurance is to be shown at the first blow: Social representations and reactions to traumatic experience *Abdelhamid Afana*	2:00 – 2:20 ABCDE's of working with traumatized refugees *Mark Kinzie & Amela Blekic*
2:20 – 2:40 Sociocultural implications of diagnosis in mild traumatic brain injury and posttraumatic stress disorder among veterans of Iraq and Afghanistan *James Boehnlein*	2:20 – 2:40 What acculturation teaches about culture *Helgi Eyford*
2:40 – 3:00 Cultural influences on trauma-related disorder and PTSD: An analytic framework *Devon Hinton*	2:40 – 3:00 Common psychotic symptoms, trauma and khat: Findings from a Somali population from a non-conflict zone *Kamaldeep Bhui*
3:00 – 3:20 State of enchantment? Narrative contours of trauma in New Mexico *Janis Jenkins*	3:00 – 3:20 Cultural perspectives on mental health literacy among immigrants to the United States *Nora Mulvaney-Day*
3:20 – 3:50 Break	
3:50 – 4:10 Effects of trauma on many ethnic groups *David Kinzie*	3:50 – 4:10 A report on refugees from Burma *Anthony Cull*
4:10 – 4:30 Trauma, the stressor criterion, and the culture of psychiatry *Allan Young*	4:10 – 4:30 Cultural consultation services for African immigrants with mental illness *Lonzozou Kpanake*
4:30 – 5:00 *Discussants: D. Hollan & L.J. Kirmayer*	4:30 – 4:50 The limits of cultural competence in the assessment of migrants with psychosis *G. Eric Jarvis*
5:00 – 5:30 Open Discussion	4:50 – 5:30 Discussion

5 – 7 PM Closing Reception – Cash Bar

Abstracts

THURSDAY, APRIL 29, AM

Introduction: Rethinking cultural competence
Laurence Kirmayer

Cultural competence has become the rubric for strategies to address cultural diversity in mental health services. Alternative constructs that have been proposed include cultural safety, humility, sensitivity, responsiveness and appropriateness. Each of these metaphors draws attention to certain dimensions of intercultural work while downplaying or obscuring others. Each perspective is rooted in particular constructions of cultural identity and difference that have social origins. Approaches to cultural competence have been dominated by work in the U.S., which configures cultural difference in specific ways that reflect its history, demography, and politics. In New Zealand, cultural safety has been promoted as a term that draws attention to issues of power and vulnerability resulting from the history of colonization. Work in other countries has favored other models and metaphors to address diversity. This presentation will unpack the metaphors of culture and competence and show their links with local ideologies of citizenship, the conceptual framing of culture in medicine, and the politics of alterity in the clinical encounter.

Revisioning the concept of culture in psychiatry: A critique
Joan Koss-Chioino

This paper examines the concept and use of "cultural competence" in psychiatry, focusing particularly on the separate meanings and relevance of "culture" and "competence" for practice, research and training. It proposes that the use of "cultural competence" as a guideline in clinical practice with patients who are viewed as culturally different from mainstream North Americans presents a conundrum and serious difficulty because: 1) the term itself is confusing if deconstructed into its two opposite meanings; and 2) it does not work with the way "culture" should be conceived and integrated into psychiatric practice. The relationship of psychiatry as a discipline to a concept of culture relevant and useful for practice and training can be constructed through an understanding of the epistemological bases of the discipline.

Rethinking cultural competence in indigenous community treatment settings: Inflections of tradition, reclamation, and post-coloniality
Joseph P. Gone

Multiculturalist mental health professionals in the United States routinely assert that counseling requires cultural adaptation for ethnoracial minority clients. Termed *cultural competence*, such adaptations typically consist of specialized knowledge, skills, and experiences that promote psychotherapeutic change while protecting the distinctive cultural orientations of "diverse" clients. Indigenous communities in North America represent interesting sites for rethinking received notions of cultural competence, owing to widespread aboriginal commitments to indigenous cultural reclamation in the context of post-coloniality. In this paper, research partnerships with diverse Native-controlled treatment settings afford opportunity for re-imagining cultural competence in light of local discourses concerning "traditional" culture. Specifically, alternative conceptualizations of cultural competence will be situated along a *continuum of therapeutic integration* that ranges between global psychotherapeutic approaches at one end and local healing traditions on the other. Brief case studies of treatment programs in two Native

communities will illuminate the prospects and pitfalls of embracing alternative construals of cultural competence along this continuum.

Reframing cultural competence as a multi-level health equity intervention
Kwame McKenzie

Cultural competence initially was considered a multi-level intervention to promote health equity. The challenge was for systems and organizations to improve access and outcomes. The plan was that they would do this by being embedded in their communities. Through this they would provide clinicians and populations with an infrastructure that would allow an equitable access to services directed by the diverse community. Unfortunately there is a stereotyped reaction to such challenges. Unless there is significant political will, the system delegates responsibility for improved outcomes to the provider organizations, and they in turn pass the responsibility to the clinician. This leads to a number of problems. Clearly the ability of the clinician to improve outcomes is significantly constrained by the infrastructure and support of the organization and the system. Clinicians target individuals; however, the perceived initial challenge was ecological. Indeed the discourse and science of improving outcomes is different at the organizational, hospital and direct care -giver levels. So much so that it is not clear that these different levels mean the same things when they talk about improved outcomes and cultural competence. This is further complicated by the fact that in most complex systems differences in values and perceptions of good are not articulated but perceived lack of progress leads to frustration. Could returning to its roots and reformulating cultural competence as a multi-level health equity intervention help communication across the different cultures within the system and so deliver better outcomes?

Unpacking cultural differences in alexithymia:
The role of cultural values among Euro-Canadian and Chinese-Canadian students
Jessica Dere

Alexthymia refers to a general deficit in the ability to identify and describe emotions. Though this construct has garnered significant research attention, it has also been critiqued as heavily rooted in 'Western' norms of emotional expression (Kirmayer, 1987). Ryder et al. (2008) found that higher levels of alexithymia among Chinese versus Euro-Canadian outpatients were explained by group differences in one component of alexithymia, externally oriented thinking (EOT); they proposed that Chinese cultural contexts may encourage EOT due to a greater emphasis on social relationships than inner emotions. The current study examined the hypothesis that EOT is more strongly shaped by culture than are two other components of alexithymia, difficulty identifying feelings (DIF) and difficulty describing feelings (DDF). Euro-Canadian (n = 296), Chinese-Canadian (n = 164), and Chinese (n = 137) undergraduates completed measures of alexithymia, and Asian and Euro-American values. Chinese-Canadian and Chinese students showed higher levels of EOT than Euro-Canadians ($p < .05$). EOT was significantly predicted by cultural values in all groups, while DIF and DDF were not, and cultural values mediated the relationship between group membership and EOT. These results suggest that cultural differences in alexithymia may be explained by culturally based variations in the importance placed on emotions, rather than deficits in emotional processing.

THURSDAY, APRIL 29, PM

Psychotherapy and migration:
Cultural competence as the new paradigm in mental health care in France
Rachid Bennegadi

The care system in France tends to be blind to culture, because of the very nature of the care system's willingness to ensure access to health care for all and the non-stigmatization of migrants. Several approaches exist in France: those which focus on the patient's culture and those which cite the language barrier.

After 40 years of experience in providing migrant and refuge mental health care (2000 new cases and 15,000 medico-psycho-social interventions per year), the Minkowska Centre made the following observations: (1) there are adverse effects that occur when we reduce the concept of illness to a cultural pattern; (2) implied stigmatisation occurs when summarising problems to language barriers; (3) there is an implicit lack of will in the French healthcare system to accept ethnic community facilities (Culture Sensitive, as in the UK for example). This paper will propose the concept of cultural competence developed through the dynamic of the confrontation of explanatory models. This can help to overcome these adverse effects when providing mental health care or support for migrant. A clinical example will be presented to illustrate this new therapeutic perspective in France.

Operationalization of cultural competence in Geneva, Switzerland:
Research, training, intervention
Patricia Hudelson

Nearly 40% of the Geneva population is foreign (180 nationalities), and physicians frequently encounter patients who differ significantly from them in terms of language, illness-related beliefs and practices and health care expectations. The Geneva University Hospitals has developed a number of research, teaching and clinical activities aimed at strengthening its institutional and clinical cultural competence. The aim of this presentation is to describe these activities, with an emphasis on analyzing the underlying notions of cultural competence that they reflect. Specifically, we will present results from a study of Geneva physicians' cultural competence, the content and aims of cultural competence training activities developed for medical students in an 8-week primary care rotation, and the activities of a general medicine cultural consultation service. The presentation will conclude with a discussion of how our approach may resemble or differ from approaches developed elsewhere.

Clinical application of cultural formulation in Stockholm
Marco Scarpinatti Rosso & Sofie Baarnhielm

The "Outline for Cultural Formulation" (CF), which appears in Appendix I of DSM-IV, is intended to serve as a clinical resource for evaluating the cultural dimension in psychiatric assessment. It consists of five elements or components (cultural identity, cultural explanations of the illness, cultural factors related to the psychosocial environment, relationship between patient and clinician and an overall cultural assessment of the diagnosis) that clinicians should explore during a psychiatric assessment. The CF has not been used much worldwide, and there is a lack of research regarding its application. We used the outline for CF to construct a practical clinical tool in the form of a semi-structured question manual in Swedish, modified and adapted to the

Swedish context. This communication presents the preliminary quantitative and qualitative findings of the systematic clinical application of the CF interviews obtained from 23 psychiatric patients with migrant backgrounds seeking help in a psychiatric outpatient clinic in a suburban area of Stockholm.

Why is 'cultural competency' not a popular term in psychiatry in India?
Sumeet Jain & Sushrut Jadhav

The term 'culture' although popular in Indian lay health terminology, remains alien to psychiatric vocabulary in the country. It is used primarily as an epidemiological variable within Social Psychiatry. A search of the term 'cultural sensitivity' and 'cultural competency' found limited use by mental health professionals in India. The authors hypothesize that the unpopularity of 'cultural sensitivity' and 'competency' terminologies among mental health professionals in the country is shaped by the a) historical origins of these terms in western 'multi-cultural societies' and time lag for their import into low-income nations; b) incongruence with perceived notions of the term 'culture' in professional health care and wider society; c) dominance of biomedical language in mental health training and practice; d) differing expectations of Indian patients from local health professionals and services and e) limited interaction between medical and anthropological disciplines within the country. The paper argues that for 'cultural sensitivity' to be relevant in an Indian mental health context, it is necessary to consider 1) an understanding of diversity within indigenous health systems, corporate and political sectors, and the work of civil society in development, poverty, caste relations, and religious conflict; 2) further ethnographic research examining patient health seeking experiences, expectations and beliefs; and 3) the relationship between cultural identities of health professionals and their clinical practice.

Clinical subcultures and competent treatment of neurasthenia spectrum disorders in four clinics of Pune, India
Mitchell Weiss, Vasudeo Paralikar & Mohan Agashe

Patients' preference for biological explanations are widely acknowledged for chronic fatigue syndrome, myalgic encephalomyelitis and comparable conditions, collectively characterized as neurasthenia spectrum disorders (NSDs), in Euro-American clinical settings. Social explanatory models and patients' explanations in India reflect diverse views and preferences that clinicians treating these challenging disorders should be aware of. Our research in urban Pune examined the range of perceived causes, priority symptoms and prior help seeking for common presentations of such conditions in four specialty outpatient clinics of an urban hospital, each with distinct orientations. In a cultural epidemiological study, EMIC interviews were administered to 352 outpatients presenting for treatment in clinics of psychiatry, medicine, dermatology (which commonly treats STDs) and Ayurved. Comparisons across clinics and cultures of categories and narratives of illness experience, meaning and behavior clarified common and distinctive features. Explanatory models of NSDs highlighted social distress, 'tensions,' physical, psychological, and cultural ideas (e.g., semen loss) generally and specifically for each clinic. Findings enable clinicians to relate clinical assessment and patients' expectations for culturally competent treatment and more effective clinical care.

Cultural competence in the context of evidence-based medicine

Rob Whitley

Cultural competence and evidence-based medicine are two powerful discourses that have become core components of contemporary psychiatry. Evidence-based medicine has particularly influenced psychiatry by spawning the enthusiastic creation and adoption of evidence-based practices. Despite their prominence, these paradigms have stood somewhat in isolation to each other. This paper explores the relationship between these two conceptual paradigms, paying particular attention to implications for evidence-based practices. I aim to stimulate a greater degree of mutual engagement and integration of these paradigms by examining epistemological, philosophical and methodological overlap and discrepancy. I argue that both paradigms can stretch and enrich each other in a positive manner. This could help achieve a situation where cultural competency becomes more evidence-based and evidence-based medicine more culturally competent.

THURSDAY, APRIL 29, PM – POSTER SESSION

The Multicultural Mental Health Resource Centre

Abdelhamid Afana, Aidan Jeffery, Eugene Raikhel & Laurence J. Kirmayer

The Multicultural Mental Health Resource Centre (www.mmhrc.ca) is a web-based portal providing information and resources on culture and mental health. Developed as a project for the Mental Health Commission of Canada, the MMHRC addresses the challenges of responding to cultural diversity in mental health care by providing access to relevant information for clinicians, patients and their families, community organizations and policy makers. Resources include: multilingual mental health information resources for patients and families; information on working with interpreters and community resources; guidelines for assessment, treatment and prevention of common mental health problems among immigrants and refugees; training materials for Continuing Medical Education (CME) in cultural competence; and access to a network for cultural consultation.

Acculturation and folk explanations of depression among Chinese-Canadians

Lauren M. Ban, Jessica Dere, Carl F. Falk, Steven J. Heine, Andrew G. Ryder

Explanations of depression differ across cultures (Kleinman & Good, 1985). Whereas Euro-Canadians often psychologise depression (i.e., describing thoughts, feelings and unconscious processes), Chinese people often use a somatic (i.e., emphasizing bodily states) idiom of distress. Using the Vancouver Index of acculturation (VIA) (Ryder et al., 2000), the current study looked at how acculturation influences depression explanations for Chinese-Canadians (N = 164). Overall the results show that Euro-Canadians (M = 5.27) offer psychological explanations of depression to a greater extent than Chinese-Canadians (M = 4.61) ($p < 0.01$) while Chinese-Canadians (M = 3.67) offer moralizing explanations of depression to a greater extent than Euro-Canadians (M = 2.83) ($p < 0.01$). In line with prediction, acculturation mediated cultural differences in depression explanations. Specifically, Chinese-Canadians who were less acculturated to their heritage culture were more likely to endorse psychological explanations (Sobel $Z = -1.98$, $p = 0.04$) while Chinese-Canadians who were more acculturated to mainstream Canadian culture were less likely to endorse moral explanations (Sobel $Z = 3.63$, $p < 0.01$).

Overall, shifting cultural norms and values accompanying the process of acculturation appear to influence the way depression is understood among Chinese-Canadians.

Integrative health in psychiatry
Lorin Boynton

Patients are showing an ever -increasing interest in and use of Integrative Health/ Complementary and Alternative Medicine (CAM) for the treatment of illnesses and wellness promotion. A survey in 1997 that included spending on CAM found that $21 billion had been spent in one year on these services. These therapies are being used by diverse populations throughout the world. Culturally competent care includes a sensitivity to and awareness of patients' backgrounds and practices in all areas of their lives. As clinicians strive to become more culturally sensitive, it is imperative that they be familiar with modalities being used by their patients and how to refer patients for appropriate integrative care. I will present the "Integrative Health in Psychiatry Curriculum" I have developed at the University of Washington. The curriculum is taught as part of the Psychiatry Residency didactic program series on "Religion, Spirituality, Culture and Integrative Health".

Roots of Resilience
Stéphane Dandeneau, Elizabeth Marshall, Morgan Phillips, Karla Jessen Williamson & Laurence J. Kirmayer

The Stories of Resilience, Healing and Transformation Project is an interdisciplinary research study examining factors and processes that promote resilience in mental health among Indigenous peoples across the lifespan. The main purpose of this study is to understand resilience, healing and recovery from the point of view of Indigenous peoples. The aim of this project is to collect life narratives to identify what is distinctive about resilience among Indigenous peoples in Canada, living in both rural and urban settings, and to identify shared and distinct sources of strengths. In collaboration with multiple First Nations, Inuit, and Métis communities in Canada, the participatory research process aims to elaborate sources of resilience through focus groups and individual narrative with youth, young adults, adults and elders.

The National Network for Aboriginal Mental Health Research
Colette Isaac & Laurence J. Kirmayer

The National Network for Aboriginal Mental Health Research (www.namhr.ca) is one of 9 Network Environments for Aboriginal Health Research funded by the Institute of Aboriginal Peoples Health of the Canadian Institutes of Health Research. NAMHR is a collaboration between academic and community-based researchers, mental health providers and Aboriginal communities and organizations that seeks to address the mental health research needs of Aboriginal people across Canada. Priorities for research are set by Aboriginal communities and are grouped into five general themes of mental health, healing and wellness. Our primary goal is to develop research capacity in graduate students in the health and social sciences. Through a variety of culturally appropriate, methodologically rigorous and ethically sound research activities, NAMHR projects and knowledge translation activities reflect ongoing consultation and collaboration with community partners.

Psychiatric subjectivity and cultural resistance: Experience and explanations of schizophrenia in China
Zhiying Ma

Despite the rapid development of psychiatry in China in the last 30 years, many patients and their families still explain mental disorders in non-biomedical terms, and seek help from traditional medical doctors or folk healers rather than psychiatric professionals. Why do these patients and families resist psychiatry? How do they resist? This study aims to address these questions through examining illness narratives in a schizophrenia ward in Southern China. The psychiatric discourse, particularly the concept of schizophrenia, embodies assumptions like Western individualism, mind-body dualism and biological reductionism that are alien to the Chinese culture. For many Chinese patients, the antipsychotic medications were troublemakers, producing side effects, chronicity, dependence, and high expense. In the schizophrenia ward, some patients and/or their families strived to mobilize alternative narratives to resist the psychiatric discourse. They resorted to Chinese medicine for a naturalistic account that rendered their experience less extraordinary. Or they subscribed to supernatural beliefs to have their extraordinary experience validated, and sought cure in a moral and cosmic order. In contrast to psychiatry, these alternatives provided holistic views that gave prominence to the role of intention, experience and agency, emphasized reintegration of the sick with the social, and advocated life styles of dynamic balance between the person and the cosmological.

The treatment of first episode psychosis in Chennai and Montreal
Alessandra Miklavcic, Srividya Iyer, Elsje van der Ven, Ramamurti Mangala & Ashok Mala

It is well acknowledged that family plays an important role in influencing the course of psychosis (Addington et al., 2004). However, little is known about what exactly families do or do not that influences the course of psychosis. Further, few studies have examined the role of families from the subjective perspective of the families themselves. The purpose of this study was to investigate their role in the lives of young people with FEP. Given that family structure and the values and expectations associated with families are impacted by the sociocultural context in which they are based, we focused on families in two different contexts – Chennai, India and Montreal, Quebec. Focus groups comprising family members of young people with FEP were conducted – at the Prevention and Early intervention Program for Psychoses (PEPP) in Montreal and at the Schizophrenia Foundation (SCARF) in Chennai. Family members at both sites shared several key similarities in terms of the "push and pull" dynamic involved in ensuring medication adherence and promoting recovery. However, the ways these were expressed pointed to moral languages with distinct features at the two sites. The discourses reflected an emphasis on imperatives and obedience in Chennai and on personal responsibility in Montreal.

Assessing emotional and behavioral symptoms in relation to school absenteeism in refugee and immigrant youth
Tonje Persson, Marie-Pier Dumas & Naomi Grenier

Past literature has found school absenteeism to be indicative of recent and possible future psychological problems in both Western and non-Western samples. In the present study, the Strengths and Difficulties Questionnaire (SDQ) was administered to a heterogeneous sample of immigrant and refugee adolescents (n = 113) attending three multiethnic high schools in Montreal

in order to assess the relation between emotional and behavioural symptoms and school absenteeism. The means of emotional and behavioural symptoms and school absenteeism were all in the normal range implying that refugee and immigrant children may not be an at-risk group overall. A strong gender effect was observed as school absenteeism was found to be correlated with externalizing, internalizing, and overall emotional and behavioural problems for girls but not for boys ($p < .05$). These results were further supported by the finding that the emotional and conduct subscales of the SDQ were correlated for girls only ($p < .05$), indicating that anxiety and acting-out behaviours may be related for female refugee and immigrant youth. Future studies should investigate the potential influence of pre- and post-migratory factors, such as exposure to violence, because they may contribute to increased risk for absenteeism in refugee and immigrant youth.

Needs assessment and development of cultural competency resources in an academic medical center department of psychiatry
Felicia Wong

Developing culturally competent clinical approaches, research, and training initiatives inclusive of minorities with mental illness is consistent with the US national mandate to eliminate racial and ethnic disparities in mental health care. To develop innovative strategies addressing such disparities, we conducted a two-part survey of the University of Massachusetts Department of Psychiatry: 1) A needs assessment highlighting critical areas development in cultural psychiatry regarding clinical practice, research, and training; 2) A follow-up survey aimed to identify cultural psychiatry resources in the region, and to prioritize areas for development. Surveys were delivered via an on-line anonymous response collector sent to 440 email addresses (Part 1), and 367 email addresses (Part 2). Respondents consisted of researchers, faculty, residents, clinicians and community representatives. With 110 completed surveys (25%), Part 1 identified a lack of cultural resources in areas of clinical services, research, and training and need for program development. In Part 2, with 56 completed surveys (15%), the lack of cultural psychiatry resources was further elicited. Respondents requested information on how to conduct research with diverse populations, working with interpreters, specific cultural groups and hiring of racial and ethnically diverse staff. We discuss implications for developing resources for addressing cultural competency at academic medical centers.

Film Presentation

Shadows and Illuminations
Robert Lemelson

"Shadows and Illuminations" is an ethnographic film addressing questions regarding how to represent and understand extraordinary experiences that appear to a psychiatric audience as clearly indicative of severe mental illness, yet other, less stigmatizing and more culturally syntonic, interpretations are possible. The film, shot over the course of 12 years in Bali, Indonesia, follows the life course of a older Balinese man, Pak Kreta, as he narrates and struggles with the continuous intrusion into his consciousness of what he terms "shadows", or spirits. The film documents his painful and traumatic personal history of trauma, loss and exposure to toxins, all of which possibly contribute to his extraordinary experiences. The film also contextualizes Pak Kreta in modern Balinese history and culture, and draws on other family members memories and interpretations of how to understand his struggles and distress. Central questions of how to

interpret these experiences, and to what role a psychiatric diagnosis and the meanings such a label entails are explored and implicitly problematized throughout the course of the film. The film also explores the role traditional healing, has in framing and treating such states in rural Indonesia. The film concludes with a consideration of how Pak Kreta has adapted and adjusted to his spirits, and how he attempts to find a small measure of peace towards the later years of his life.

FRIDAY, APRIL 30, AM

Globalization and substance use and abuse among Samoan adolescents

Harold Odden

"Globalization" represents an analytically useful lens through which to understand adolescent substance use and abuse in many parts of the developing world. The accelerated movement of peoples through migration, the increased availability of different psychoactive substances, and the flow of diverse cultural meanings likely exert substantial influence on patterns of substance use across cultures. Arguably this is particularly so for adolescents, who may be the "leading edge" of globalization due to their social positionality and heightened exposure to non-traditional ways of life. Globalization is not a singular phenomenon, however, but rather a complex set of processes. This paper examines the relative impact of three specific aspects of globalization on substance use in a population of urban Samoan adolescents (n = 855) who took part in a recently completed epidemiological study of adolescent health. The study compares the predictive strength of (1) length of time spent overseas, (2) relative exposure to non-traditional lifestyles through Western media, and (3) discordance between earlier and contemporary levels of exposure to Western culture and non-traditional lifestyles on substance use behaviors. Logistic regression analyses suggest that it is the latter of these models, which has the greatest predictive value.

Searching for the evidence: Emerging dilemmas of humanitarian interventions in complex emergencies

Hanna Kienzler & Duncan Pedersen

We present the results of a review of the scientific literature on individual and collective humanitarian interventions within the domain of mental health in civilian populations in low and middle-income countries (LMICs) affected by political violence and contemporary wars. Based on the review, we challenge the assertion that the medical and allied professions are best qualified to deal with the worst humanitarian and medical emergencies in the world today. This may be partly due to the lack of a sound empirical and theoretical base supporting what needs to be done. In addition, we discuss three major implementation gaps: 1) the delayed response: controlled early interventions are neither conducted, nor properly evaluated; 2) the neglect of the role of endogenous protective factors at play, such as resilience, social cohesion, or social support networks, and their influence in the process of natural recovery; and 3) most reported interventions are limited to the use of symptom check-lists and provision of one form or another of psychotherapy, trauma counseling or general psychological support, with no attempt to assess and validate treatment outcomes (i.e., random allocation of cases and controls). We argue that the diversity of research paradigms and approaches, and the tensions between front line responders, clinicians, humanitarian agencies, and international organizations, generate many dilemmas in conducting interventions in complex emergencies, which need to be specifically addressed, especially in low and middle-income countries (LMICs).

Enforcing Cultural Competence: Domestic Abuse in a South India Village
Helen Ullrich

Culturally endorsed domestic abuse is a prime example of sanctioning women who transgress societal values. While the culturally competent avoid abuse, they are aware of the parameters of appropriate behavior. Domestic abuse contributes to suicidality, helplessness, and hopelessness as symptoms of depression. This paper focuses on four generations in a South India village. In the first generation domestic abuse was common. Wives had no recourse and frequently believed that they were at fault. In the second generation with the advent of education domestic abuse became less frequent. However, these women still felt ashamed when they were victims of verbal or physical abuse. Depression and suicidal ideation often were present among abused women. Women of the second generation talked of their shame. The more highly educated third generation developed other options beyond enduring abuse. In the third generation once abuse became public, the woman resided with her parents until a formal mediation reconciled the couple. Physical abuse in the fourth generation is culturally unacceptable and grounds for a permanent separation or divorce. In this talk I illustrate the impact of changes in perception of cultural competence on domestic abuse, depression, the marital relationship, and women's sense of agency.

Cultural psychiatry and intractable conflicts
Steven Wolin

Year after year, the world suffers from the staggering consequences of intractable cultural conflicts, destroying or seriously damaging the societies' underlying physical, socio-economic, and governmental infrastructure. Finding ways to grapple with these problems is clearly of the highest international priority. Transcultural psychiatrists have not addressed the relevant issues in cultural conflicts, despite their expertise in the interplay of psychological, social and cultural forces. The author believes our discipline can contribute to the understanding and resolution of such conflicts. This presentation will offer an overview of intractable culture-based conflicts by touring www.beyondintractability.org, a primary online resource in the field. Topics to be covered include the nature and underlying causes of intractable conflicts; the importance of identity and worldview frames; stereotyping and forming enemy images; psychological and social processes that maintain intractable conflict; moral or value conflicts; cross-cultural communication in dispute resolution and the post-conflict transition to peace. A future course in conflict resolution and reconciliation will be discussed.

Mutual Creative Space:
A translation of cultural competence into an action-model in mental health
Gadi BenEzer

While the term "cultural competence" has become popular in recent years (Kirmayer, 2010) there are not many "translations" of its general recommendations into systematic action-models within the inter-cultural encounter. This fact has led, I believe, to a significant gap between its potential application and its actual use, with particular difficulties arising in the education and training of professionals in the mental health services. This paper aims to partially fill this gap by proposing a more systematic way to approach the intercultural encounter. Following the last developments

of the concept I developed the term "mutual creative space", in which seven categories would be presented for diagnostic/analytic and intervention/treatment as well as for training purposes. These include: recognizing the difference; acceptance; adoption; appreciation; ideal for action; invention; and full rejection. This action-model could be applied in working with individuals, families, groups, communities, and as a tool for organizational change in mental health and other organizations. Suggesting "intercultural negotiation" as its 'axis', and providing a more systematic method for dealing with the encounter, this concept could serve as a 'buffer' for the natural anxieties that arise while facing 'cultural difference/strangeness', and as a guiding tool for action. The discussion will include some recent examples of applying this concept in intervention and training.

Adapting and transforming services and interventions across cultures: Identifying cultural services preferences
Les Whitbeck & Melissa Walls

This paper addresses services preferences of 971 parents/caretakers of Indigenous adolescents ages 10 – 12 years who live on or near reservations and reserves in the northern Midwest U.S. and Western Ontario, Canada. The adults were asked about the perceived effectiveness of formal and informal sources of help for emotional problems and alcohol and drug problems for themselves and for their children. For emotional problems, the adults' top eight preferences for help were traditional: 1) family member, 2) talking to an elder, 3) offering tobacco and praying, 4) traditional healer, 5) healing circle, 6) traditional ceremony, 7) sweat lodge, 8) pipe ceremony. All of these were listed prior to mention of a formal services provider: counselor on reservation. The least preferred sources of help were social workers off-reservation/reserve (ranked 21st, 12.6%) and on-reservation (ranked 22nd, 10.4%). Rankings differed slightly for emotional problems of their children. The top five sources of help were informal traditional sources: 1) family member, 2) talking to an elder, 3) offering tobacco and praying, 4) traditional healer, 5) traditional ceremony. The first formal source of help was an on-reservation/reserve psychiatrist which was ranked 6th. This was followed by two more traditional sources: healing circle, ranked 7th and sweat lodge, ranked 8th. Preferences for alcohol and drug services followed similar patterns for both adults and children. However, when adults who said they actually had an emotional problem were asked to whom they turned, family doctor was the second most mentioned source of help after family member. A similar pattern was found for alcohol/drug problems with substance abuse counselor mentioned after family members. It appears that although there are strong preferences for traditional sources of help few actually sought these out in times of need. Possible reasons for this apparent gap in preferences and behaviors will be discussed as well as the need to interface traditional and formal services to increase services utilization.

Cultural competence in medicine
Jon Streltzer

The Institute of Medicine has reported on widespread disparities in health care among various minority and cultural groups. It has encouraged the acquisition of cultural competence as one remedy for this problem. Misunderstandings in doctor patient communication are more likely to occur when the doctor and the patient have different cultural backgrounds. If cultural issues cause a problem in communication, doctors tend to blame the problem on patient shortcomings. Residency training programs in all specialties are increasingly recognizing the importance of including cultural competence in their curricula to promote optimal patient care. Surveys of

residents however, indicate that relatively little time is actually allotted to cross-cultural issues, and there is little in the way of role modeling. In a medical setting three types of culture are present and interact with each other. These include the culture of the patient, the culture of the physician, and a specific medical culture. A "medical culture" can be said to exist when specific values and beliefs unsupported by scientific evidence determine medical practice. This is exemplified by varying pain management practices in different countries.

The cultural context of methods, practices and policies
Luis Vargas

This presentation will address methodological issues pertaining to the development of evidence-based treatments (EBTs) and the application of EBTs to culturally diverse populations. The cultural context of current EBTs and evidence-based practice (EBP) will be examined. Strategies to develop culturally responsive EBTs and to engage in EBP will be presented. Policy and ethical implications associated with the dissemination of "standard" EBTs for use with culturally diverse populations will be discussed. .

Accreditation and Training in Cultural Competence
Francis Lu

This presentation will review cultural competence and diversity as seen in accreditation standards for medical schools in the US and Canada (LCME) and general psychiatry residency training programs in the US (ACGME). Following the Liaison Committee on Medical Education (LCME)'s 2000 standards on cultural competence curriculum (ED 21, 22), the LCME enacted IS-16 effective July 2009 that focused on infrastructure, polices, and procedures that support diversity and inclusion. The Association of American Medical Colleges has responded to these new standards with both the 2005 Tool for Assessing Cultural Competence Training (TACCT) to assist medical schools in assessing training in cultural competence and the 2009 AAMC Group on Diversity and Inclusion to support medical school infrastructure on diversity and inclusion with a focus on faculty and house staff. The Accreditation Council for Graduate Medical Education (ACGME) accreditation standards effective July 2007 for general psychiatry residency training programs will be reviewed focusing on sociocultural issues found in 5 of the 6 core competencies. The ACGME standards are in the initial stages of review for the 2012-3 revision; ongoing advocacy for cultural competence and diversity will be needed.

The resident perspective:
Pros and cons of cultural linguistic matching patient to provider
Felicia Wong, Daniel Fallon & Jacqueline Smith

Ethnic minorities comprise approximately one third of the US population, yet are underrepresented among people receiving mental health services. Disparities in the use of mental health services can be attributed to factors including language, culture-specific stigmas, religious barriers, and the subjective impression that the mental health system is hard to navigate and may not provide appropriate care for them. Research indicates that matching clients from a minority group with clinicians from the same background may increase community mental health services utilization and reduce emergency room use.

We will explore the strategy of cultural and linguistic matching using three scenarios:
1) A Hispanic resident will discuss his experience seeing Spanish speaking patients,

2) A Muslim resident will share her experience working with the Muslim population,
3) An African-American resident will share her experience seeing African-American patients in her clinic.

We will evaluate the pros and cons of this strategy. When a culture-matched patient/trainee dyad is found, will other differences be ignored? Will this benefit or harm the patient? What are the concerns regarding confidentiality when the community is small? Will exposure to culturally diverse groups be limited for other trainees if only minority residents are expected to see minority patients?

Transcultural psychiatry discussion groups:
A space for reflection, inquiry and sharing food
Michaela Beder, Layla Dabby, Rachel Kronick, Alpna Munshi, Priya Raju & Lori Wasserman

Due to perceived gaps in their training, groups of residents at two Canadian psychiatry programs (McGill University and the University of Toronto) have created similar spaces to discuss transcultural psychiatric issues from a critical perspective. The discussions revolve around cultural psychiatry, and challenge the culture of psychiatry itself. Participants reflect together on what it means to be a member of the mental health field, whether as a clinician, an academic, or a patient. As interdisciplinary groups, we have welcomed members from a variety of backgrounds including occupational therapy, chaplaincy, anthropology, psychology, social work, architecture, and philosophy, and each person has brought a unique view to the group. While this process has been largely positive, it has not been without challenges, both structural and personal. In this session we will provide examples of these challenges, and discuss how being part of these groups has influenced our own practice and understanding of cultural psychiatry. There will be time for questions and we hope to foster a discussion on how cultural psychiatry training can be improved across residency programs, using the lessons learned from our discussion groups.

FRIDAY, APRIL 30, PM

Cultural Formulation Scale: A tool for the improvement of cultural competence
Renato Alarcon

Accurate diagnostic practices are considered a cardinal component of cultural competence in the psychiatric field. Such accuracy can only be thorough if the cultural factors are carefully assessed and duly taken into consideration. The inclusion of the Cultural Formulation (CF) in DSM-IV opened the way to a more systematic evaluation of key cultural variables in the diagnostic process, and was seen as a promising tool for clinical and research purposes. This presentation will examine the main reasons for an uneven utilization of the CF in both, educational/training and purely clinical areas. It also will address its consideration in the ongoing development of DSM-V, focusing on the advantages and disadvantages of the existing CF, as seen by clinicians, trainees, educators and researchers. The strong trend toward quantification in several areas of the DSM-V work, leading to the adoption of dimensional measures, cannot be ignored by those interested in a fully defined presence and acceptance of culture in the new nomenclature. In addition to an exclusively narrative form, a CF Scale can offer the practitioner a measurement instrument of high practical value. Accordingly, the main features of a CF Scale are described. They are based on the items or areas present in the existing DSM-IV's CF, plus others extracted

from recent literature and strong clinical experience. The ensuing discussion can enhance the purposes, structure and usefulness of the proposed Scale, conceived as a tool that could, advantageously, improve a much needed comprehensive cultural competence covering the diagnostic and the therapeutic fields of psychiatry.

The cultural formulation in DSM-V
Roberto Lewis-Fernandez

The phenomenology of psychiatric disorders across cultures shows strong differences as well as commonalities. Cultural groups may describe psychopathology in more psychological or more somatic terms, or cluster syndromes in alternate ways, connecting symptoms together that other cultures do not acknowledge as related. Psycho-anthropological research on this cultural variation reveals that our current psychiatric diagnoses are somewhat arbitrary confluences of pathological processes that are fundamentally dimensional and contextual, an awareness that is also emerging from neurobiological research. Our diagnostic manuals, however, classify illnesses on the basis of descriptive, reified categories rather than contextualized dimensions. What is the role of this categorical type of nosology in a contemporary program of research on mental illness and its treatment? In particular, does categorical description and classification add anything beyond a more dimensional study of psychopathology? This talk will present an approach that uses cross-cultural categorical classifications of mental illnesses as heuristically useful natural experiments in the clustering of psychological dimensions, socio-cultural contexts, and neurobiological substrates. By observing the inter-relationships among these levels of analysis as they covary across cultural settings – "triangulating" them – this approach should help clarify the core phenomenological elements of the disorders as well as their socio-biological underpinnings. To illustrate this approach, we will focus on two cultural syndromes that are related to dissociative symptoms and disorders: *ataque de nervios* (attack of nerves) and pathological possession trance. The role of DSM-V in this research agenda will be discussed, including specific suggestions for revisions to the Manual.

Incorporating diverse needs and strengths into the development of a mental health strategy for Canada
Farah Mawani

The Mental Health Commission of Canada (MHCC) is an arms-length, federally funded, non-profit organization. As part of its mandate, the MHCC is working to develop a mental health strategy for Canada. The first phase of mental health strategy development was completed in November 2009, with the release of the strategy framework document '*Toward Recovery and Well-Being'.* The document presents the vision and seven high level goals for mental health system transformation, which draw on input reflecting the experience and thinking of thousands of people from across Canada. The second phase of strategy development focuses on translating the framework into a comprehensive strategic plan for HOW to achieve the framework vision and goals. This workshop focuses on Goal Three of the strategy: "The mental health system responds to the diverse needs of all people in Canada." A *Diverse Needs and Strengths* background paper will be circulated prior to the workshop. It will outline what we know now, what further work needs to be developed, and potential strategic directions to realize Goal Three. Input will be sought for an Issues and Options Paper that will inform priority setting on meeting diverse needs and incorporating diverse strengths within a transformed mental health system.

Developing a cultural competence plan for health care organizations
Kenneth Fung, Ted Lo, Lisa Andermann, Rani Srivastava & Janice Dusek

Cultural Competence (CC) is increasingly recognized as an essential component of effective mental health care delivery to address diversity and equity issues. In this presentation, drawing from the literature and our own experience in providing CC consultation and training, we will focus on cultural competence as it applies to an institution and its programs and services, as well as to healthcare providers. We will present the methodology we used recently in conducting an organizational cultural competence assessment at a health care organization, using both quantitative and qualitative data. Organizational culture and principles and strategies of implementing a cultural competence plan will be examined, as they influence the likelihood of success in creating a paradigm shift. Finally, we will present our organizational cultural competence framework, which may be applicable to other healthcare settings and can be used for organizational assessment and cultural competence planning, ultimately aiming at enhancing mental health care service to the diverse patients, families, and communities. Attendees of this workshop will be able to participate in interactive group exercises to learn about organizational cultures; the use of an organizational cultural competence framework to evaluate their own healthcare organizations; and the skills of developing a cultural competence plan.

SATURDAY, MAY 1, AM

Use of cultural consultation to resolve uncertainty in the diagnosis of psychosis in African immigrant patients
Ademole Adeponle, Laurence J. Kirmayer, Brett D. Thombs & Danielle Groleau

Misdiagnosis of psychosis in ethnic minority patients has been reported, with reported risk factors for misdiagnosis including younger age, male gender, black ethnicity, acculturation-related difficulties, language and communication difficulties, and referrals pathways that involve the criminal-justice system. A number of care models have been developed to aid delivery of culturally appropriate mental health services in multicultural settings, cultural consultation being one such model. Research on how these models address cultural and ethnicity-related bias in diagnosis, however, remains sparse. In this study, we analyzed data from a cultural consultation service to determine the extent and pattern of change in diagnoses resulting from systematic consideration of social and cultural consultation. We reviewed the case records and case conference transcripts of 23 patients of sub-Saharan African origin referred for assessment of possible psychosis. A three-step process in re-assessment of diagnosis was identified: (1) problematizing the original diagnosis by introducing contextual factors; (2) explaining the symptoms of psychosis in terms of biological, psychological or social processes; and (3) confirming or re-interpreting the diagnosis of a psychotic disorder. This process sheds light on psychiatric reasoning in complex cases and can be used in refining cultural competence training and service delivery.

Redefining personality disorder: A Jamaican perspective
Frederick Hickling & Vanessa Paisley

Case-control study by a Jamaican psychiatrist 1974 to 2005 in a private Jamaican psychiatric practice assessed whether phenomenological features of personality disorder in Jamaican patients fit conventional DSM-IV personality disorder categories. Patients (n = 351) diagnosed with DSM IV Axis II personality disorder categories were matched for sex, age, and social class with a control group of patients without a diagnosis of personality disorder.
M:F = 166 (47%):185 (53%); 50 (14%) white Caucasian; 301 (86%) black African-Jamaican; 293 (84%) born and raised in Jamaica; mean age 33.92, SD 10.236, with 202 (58%) from SEC I&II. Disaggregating the phenomenology, the conventional DSM IV personality disorder diagnoses disappeared. Factor analysis of 38 clinical phenomena identified 5 components; two indicated features of psychosis and major depression; three classified as power management; psychosexual issues; and physiological dependency. A *t*-test revealed patients without personality disorder had significantly higher mean scores for psychosis; both groups scored equally for depression; those with personality disorder had significantly higher mean scores on the remaining factors. The phenomena clustering into 3 major groups suggested an Axis I diagnostic disorder of *inter and intra-personal power*. The term *Shakatani* from the Swahili words *shaka* (problem) and *tani* (power) is proposed as a possible name for this revealed unitary condition.

Racism, depression and cultural competence in the diagnosis of African Americans
Larry Merkel

Epidemiological surveys of the rate of depression in African Americans demonstrate that the rate is no higher than that found in White American populations. However, other epidemiological research and anthropological and sociological studies, suggests that this conclusion is not accurate. African Americans have higher rates of a number of medical conditions in which exposure to chronic racism is felt to play a role and where depression may be a mediating factor. This suggests that depression may likely occur at higher rates. Furthermore, a large percentage of at risk members of the African American community are not available for epidemiological evaluation, because they are in institutions. African Americans continue to be diagnosed with psychotic disorders at higher rates. Psychiatric epidemiology therefore may under represent the degree of mental health disorders among African Americans, minimizing the impact of racism. Cultural competence discourse pertaining to African Americans tends to focus on disparities in utilization, emphasizing the clinician-client relationship, but does not address the role national and institutionalized racism play in African American mental health. This paper will review this literature and make the argument that present emphasis within cultural competence on the doctor-patient relationship and the use of questionable epidemiological data reinforce racism.

Differential diagnosis between spiritual experiences and mental disorders
Alexander Moreira-Almeida & Adair De Menezes Jr.

There is an increasing literature showing a high prevalence of psychotic and dissociative symptoms in the general population. However, most of our knowledge of those experiences is based on clinical, often hospitalized, samples. Spiritual experiences can be confused with psychotic and dissociative symptoms, often being a challenge for the differential diagnosis. Based on a wide literature review and a study we performed with 115 Brazilian spiritist mediums, we aimed to identify criteria for a differential diagnosis between spiritual experiences and psychotic

or dissociative disorders. Mediums reported a high level of psychotic and dissociative experiences. However, these experiences were not correlated to other markers of mental disorders such as scores on social adjustment, other psychiatric symptoms, and history of childhood abuse. The sample had a high socio-educational level, a low prevalence of mental disorders and was socially well adjusted. It seems that psychotic or dissociative experiences are not necessarily symptoms of mental disorders. Certain features may suggest a non-pathological basis for the experience: lack of suffering or functional impairment, short duration of the experience, critical attitude (to have doubts about the reality of the experience), compatibility with the patient's cultural background, absence of co-morbidities, control over the experience, and personal growth over time. These criteria are useful pointers, but there is a lack of well-controlled studies.

Cultural expertise in the service of racism:
A reflection on the counter-therapeutic risks of the cultural competence model
Marie-Eve Cotton

Critiques of the cultural competence model have pointed out that it may perpetuate a static, generic and homogenous view of culture, as well as promote an encyclopedic and technical approach to the provision of culturally appropriate care. In clinical settings, naïve applications of such model carry the risk of reinforcing the standardization of culture. In this presentation, it will be argued that beyond failing to convey the indeterminate and fluid nature of culture, the notion of cultural expertise may, in some contexts, serve racist discourses. Based on extracts of a forensic psychiatry evaluation regarding a young Inuk who committed an assault, I will discuss how the expert's reasoning speaks for an "inferiorization" and "folklorization" of the Inuit culture, reinforces the stereotype of the "violent and primitive Native", and thus reasserts the power imbalance which has historically characterized the relationship between Caucasians and Natives in Canada. I also will reflect on how, in this case, failure to promote the institutional dimension of cultural competence has allowed such a fall into racism.

Language as a journey in clinical space:
Moving toward cultural sensitivity in transcultural psychiatry
Sylvaine de Plaen

In the last few years, different authors have advocated for developing a cultural sensitivity model rather than adopting the cultural competency frame for transcultural work. The shortcomings of cultural competency are obvious in transcultural practice, as patients do not always recognize their own reality and experience in the often restricted or stereotyped cultural frame proposed by clinicians. To be closer to their real experience, we advocate for an approach that will let the patients lead and decide where culture lies for them, recognizing the creolizing reality of their life and of post-modern societies. In this vignette, we will discuss a case where use of maternal language has been at the core of the therapeutic work for a "second generation" young woman presenting with severe depressive symptoms.

Blinded by one's own expertise: Ethic matching and transitional spaces
Constantin Tranulis

There is a growing expectation toward training clinicians to become culturally competent. I am one of the many psychiatrists who happily succumbed to this pressure and learned a general approach to work in trans-cultural contexts using cultural brokers. During my clinical work in a

first episode of psychosis clinic, I was ethnically matched to my patients on two occasions. It was a puzzling experience for me to discover that this ethnic and cultural matching (which rendered spurious the use of an interpreter or cultural broker), hindered the capacity to develop a strong alliance and use cultural elements constructively in the therapy. In retrospect, I identified the confidence in my "cultural expertise" in these cases as clinically counterproductive. After briefly presenting the two clinical cases, I will propose a reflection on the active ingredients of using culture in clinical work, emphasizing the importance of the construction of a transitional space. There is a growing tension between the capacity for inter-subjective encounters, which take seriously the role of culture and the development of expert discourses on culture. The mainstreaming of cultural competence deeply transforms the politics and power relationships in clinical encounters and will likely exacerbate the tensions and shortcomings discussed in this presentation.

The meaning of physical symptoms for patients and mental health clinicians
Nicholas Carson

This presentation reviews how patients of diverse cultural backgrounds make meaning of physical symptoms during mental health intakes, and how clinicians assess and respond to these symptoms. 129 intake interviews with Latino, black, and non-Latino white patients were videotaped (47 mental health clinicians from eight Boston clinics.) 120 videos were coded using a checklist containing 21 physical illness items. 28 intake visits exemplifying physical illness assessments were transcribed for qualitative analysis. Clinicians elicited information on physical health in 79 visits (66%), while patients volunteered such information in 80 visits (67%). Frequency of assessment differed by clinician discipline ($p < .05$) and patient ethnicity ($p = .06$), with Latino patients being screened the least. Appropriate clinician assessments noted physical side effects of medications, encouraged patient contact with medical providers, promoted physical health care, and included physical conditions in the psychiatric differential diagnosis. Patients spoke of physical symptoms, particularly pain, in terms of fragmentation of the self and loss of culturally relevant social roles. Assessment of physical symptoms can therefore help mental health clinicians clarify "what matters" for patients (Kleinman 2006, Katz & Alegria 2009). Reformulations of "culturally competent" psychiatric care should therefore include opportunities for patients to elaborate on the impact of physical symptoms in their lives.

Impact of the use the DSM-IV outline for cultural formulation on the dynamics of multidisciplinary case conferences in mental health
Nathalie Dinh

The growth of cultural pluralism in North American society has required the mental health community to show a higher level of cultural sensitivity. Mental health professionals must not only be aware of the social and historical context of their clientele, but also of their profession. Clinical evaluations provide the information for clinical care. This information must be examined in a cultural-sensitive framework for assessment and case formulation that permits an accurate diagnosis across the cultural boundaries of both patient and mental-care professional. The Diagnostic and Statistical Manual of Mental Disorders (4th ed., DSM-IV; American Psychiatric Association, 1994) sets forth an Outline for Cultural Formulation (CF). It instructs clinicians not only on how to elicit culturally relevant clinical material, but also on how to assess the importance of the diverse cultural perspectives of patients and their families, thus increasing usefulness of their own cultural knowledge in treatment. This study is a conversational analysis of

the nature and application of knowledge within a clinical, interdisciplinary context. It uses an expanded version of the CF as a framework, in which the discursive practices of mental health professionals are evolving. From a symbolic interactionist perspective, it examines the way different disciplines interpret and conceptualize cultural elements and the implications of this framework for interdisciplinary collaboration of assessment, treatment plan, and care.

Where the exception becomes the norm — At the juncture of culture, trauma and psychiatry: Applying Agamben's "state of exception" to trauma studies and cultural competence
Vincenzo Di Nicola

Cultural competence represents a radical shift in psychiatry away from mind and psychopathology toward the skill set of the clinician. Whether based on a categorical-nomothetic approach or a phenomenological-idiographic approach, symptoms point to experiences that are troubling, particular and specific to the individual.

Cultural competence shifts psychiatry's task in two critical directions:
• the anthropological-hermeneutic reconstruction of the sufferer's world (the cultural component);
• the competence of the psychiatrist (the competence component).

This moves from the symptom as a particular problem of a given individual toward a shared, social view of illness and, in a more distancing gesture, toward the competent construction of the experience by an observer. These tasks are at odds with each other. For anthropological-phenomenological knowledge to be made into technical skills there must be a phenomenological reduction.

This critique is then applied to trauma studies. Both as description of the world we live in and as critical comment upon it, philosopher Giorgio Agamben shows that we live in a time where man as a form-of-life has been instrumentally reduced to a state of exception, to the walking dead of Auschwitz, which Agamben characterizes as bare life. In trauma studies, the state of exception—with Auschwitz as its emblem—has become the rule. When the exception becomes the norm, desensitization endangers our "humanness." Rendering historical, phenomenological and philosophical insights about the exceptional character of trauma into a culturally competent set of clinical skills risks turning trauma studies into reductive tools, instruments or means to an uncertain end.

Cultural distance and treatment negotiation: Study from Sundarban Delta, India
Arabinda Chowdury

The Sundarban region is the largest delta in the world standing at the confluence of the Ganges-Hooghly river and the Bay of Bengal. It spans the southern most part of the state of West Bengal in India and the neighbouring regions of Bangladesh. There are 54 small islands here spread over an area of 1630 sq. km that is intersected by numerous canals and tidal creaks. The area is underdeveloped socioeconomically owing to relative inaccessibility, constantly changing landmasses due to tidal inflow, and adverse climate conditions.85% of the inhabitants are dependent on subsistence cultivation and 15% on fishing and forest exploration (timber and honey). Out of 13 administrative blocks under South 24 Parganas district, six blocks are island blocks including Namkhana. The present paper illustrates with two case studies how the treatment offered for mental health problems was rejected by family members unless it was endorsed by

local health care providers (HCP- quack doctor). This unfolds a series of cultural epidemiology field work to negotiate first with the local HCPs about mental illness and their treatment in addition to local healing for mental distress. This involves survey of the HCPs in each village of Namkhana block and subsequent training of the HCPs on mental health, which resulted in the delivery of a culture-conducive community mental health service to this island population.

Evolving understanding of cultural sensitivity in the Christianization of India
John M. de Figueiredo

After the conquest of Goa by the Portuguese in 1510 European missionaries came to India to spread the Gospel of Christ and convert the local people to Catholicism. To attract the Hindus to the Catholic religion, the missionaries used persuasion, kindness, and charity; meticulous study of the local culture; dramatization of the Christian themes; and magnificent public display of religious services. The Christians studied Hindu classics and published "Christian Puranas' as well as poems, grammars, vocabularies and dictionaries in the local languages. They founded hospitals and colleges that attracted students from various countries of the East. They captured the intellectual curiosity of the natives by teaching them religion, philosophy, science, literature and the fine arts. Initially, being "Christian" meant being "European". The conversions were viewed as "package deals" in which the converts were expected to take a Portuguese name, speak Portuguese and adopt a European lifestyle. Eventually it became clear to the missionaries that penetration into the Hindu culture required that Christianization be divorced from "westernization". The end-result of the Christianization in Goa was the development of a hybrid culture in which the Christian and western themes were presented and understood in Indian forms.

The application of cultural psychiatry to office practice
Houshang Hamadani

Most of the current America-European literature consists of research on minority populations or new immigrant communities from Asia and Africa, while the older literature mainly describes culture-bound syndromes in developing Third World countries. What is less often presented is the impact of culture on everyday office practice. Based on over forty-three years practice in the Northeastern United States, Hawaii, French Canada and Iran, the author suggests that the use of cultural psychiatry can complement individual psychotherapy. This is especially useful when most of the patients are also treated with medication. The awareness of ethnic and national origins of patients will help the clinician establish rapport. Knowledge of the traditions, religions, rituals and political affiliations of the group to which the patient belongs will enhance the psychiatrist's ability to communicate. Examples of patients treated by this method in the author's office practice are also presented.

Fetishism, inalienability, and material culture: A case study in compulsive hoarding
Yavar Moghimi

The desire to collect objects is universal. Some collections gain such notoriety that money can be charged to view them (e.g., art collections). Collecting objects can give people a sense of control over the world by breaking it down into smaller categories that can then be displayed to others. In contrast, cluttering is a secretive holding of objects that ends up engulfing usable space. The distinction between one person's collection and another's clutter comes down to whether or not it

is considered to have social value. At its most extreme, clutter can devolve into an insatiable yearning for objects and an inability to discard them known as compulsive hoarding. In some instances, hoarding of objects can be seen as utilitarian and 'rational' as in the hoarding that often occurs in response to unstable economic situations, such as a change from state to market based systems (Loffman, 1993). Historically, hoards of items also have been seen throughout various times in anticipation of food shortage, as seen in the Anasazi tribe of the Southwest (Dossey, 2005). In psychiatric practice, however, hoarding of a more 'irrational' nature is frequently encountered (Csikszentmihalyi, 1988). Compulsive hoarding recently has been brought out of the closet, with a flurry of books, movies and reality shows highlighting it. This increasing interest in compulsive hoarding comes at a time when Americans are questioning their consumptive patterns more than ever. In this context, hoarding "can be read as a metaphor for an entire culture that has lost perspective on the relative importance of things and desperately needs help" (Walker, 2009: MM14). The purpose of this paper is to expand on the psychiatric understanding of compulsive hoarding by drawing on the extensive literature in the social sciences on people's attachments to objects and illustrating them with a case study. Introducing this other perspective brings into consideration the idea that pathological hoarding is an extreme of a normative human desire to accumulate objects.

SATURDAY, MAY 1, PM

Endurance is to be shown at the first blow: Social representations and reactions to traumatic experience

Abdelhamid Afana

Research and clinical practice in the field of trauma has emphasized the construct of PTSD. However, trauma has broader meanings that reflect its impact on the fabric of social life and that may be relevant to clinical understanding and intervention. This paper illustrates the larger meanings of trauma with data from a pilot study designed to investigate the social representations of trauma and ways in which trauma is defined (i.e., meanings assigned to trauma), among Palestinians living in protracted conflict situations in the Gaza Strip. Ethnographic interviews conducted with key informants living in the Gaza Strip suggest that social representations and meaning of trauma can be classified into three main types according to the level and nature of the symptoms associated with the experience, severity, patterns of resort to treatment and prognosis: *sadma* (trauma as impact), *faji'ah* (tragedy) and *musiba* (calamity). *Sadma* is used metaphorically to refer to painful events that happen suddenly. *Faji'ah* is used to describe the reaction to an extraordinary event, mainly the loss of a loved one. *Musiba* is used when traumatic events are persistent and have long-term consequences. Popular descriptions and relationships among these terms and their meanings are illustrated. Examining cultural variations in the understanding and expression of trauma-related distress has implications for the definition of trauma-related disorders in psychiatric nosology, as well as for the design and delivery of culturally appropriate clinical and community interventions.

Sociocultural implications of diagnosis in mild traumatic brain injury and posttraumatic stress disorder among veterans of Iraq and Afghanistan
James Boehnlein

Because of the nature of the conflict and the weapons used in the wars in Iraq and Afghanistan, the prevalence of blast injuries has been high among soldiers returning from combat. Many of these injuries have been obvious, with loss of limbs and hearing loss. However, more subtle effects of blast injuries that cause trauma to the brain have been more difficult to quantify. Mild traumatic brain injury (mTBI) has been recognized following head trauma, but usually in the context of impact-related trauma. It is a condition that includes memory impairment, headaches, nausea and behavioral/emotional changes, and it traditionally has been very difficult to diagnose with neuroradiological techniques. In addition, it may be comorbid with posttraumatic stress disorder (PTSD), another condition that may follow combat that also is difficult to objectively quantify. This presentation will briefly discuss the diagnostic challenges faced by clinicians for decades in trying to accurately describe the psychological impact of combat trauma. In addition, this presentation will explore the sociocultural implications of medical diagnoses, including diagnoses as idioms of distress, when there is the question of mTBI and PTSD comorbidity: implications for effective treatment; the impact on the veteran's financial future through the VA compensation and pension process; and, the role of diagnostic stigma in how the veteran, his/her family, and American culture view recovery and familial, vocational, and social reintegration.

Cultural influences on trauma-related disorder and PTSD: An analytic framework
Devon Hinton

In this presentation, I will discuss how and why trauma-related disorder varies across cultures. Such variation includes the meaning of the trauma (e.g., the supposed effects on the mind and the physiology of the body), the stigma associated with having been traumatized (e.g., the extreme stigma of rape in certain cultures), syndromes attributed to being traumatized (e.g., *susto* in Latin America), the meaning of the trauma- and PTSD-caused symptoms, the particular syndromes to which PTSD symptoms are attributed (e.g., "Gulf War syndrome"), multiplex looping (the way in which a certain illness reality is created by the way that symptom meaning and associations interact with the biology and psychology of anxiety, the way that these loops are initiated by particular triggers), the economic, identity, and interpersonal consequences of having syndromes attributed to PTSD symptoms (e.g., economic benefits), and the types of healing techniques for trauma and its symptoms and syndromes and the consequences of being treated by those means (biological, such as drug effects, or psychological, such as those that result from certain healing rite: shifts in body state, mental maps, and identity). Through these and other various mechanisms, trauma has a very particular socio-cultural course, results in a very specific trauma ontology.

State of enchantment? Narrative contours of trauma in New Mexico
Janis Jenkins

The lives of severely troubled adolescents and their families as narrated through discourse on trauma presents a challenge for interpretability of situations of structural violence. What does it mean when chaos and inability to interpret are experienced not as sources of frustration and suffering but rather as taken for granted conditions of raw existence? This paper examines this question on the basis of ongoing ethnographic work for an NIMH-funded study of adolescent

mental health among a multi-ethnic group of youths in New Mexico who regularly relocate across a range of social and institutional settings (kin-based household, inpatient psychiatric hospital, residential treatment center, foster care, detention). A case study of a youth who has been exposed to discreet and chronic conditions of trauma and rupture is analyzed. Shifting frames of social and biomedical reference contribute to the formation of subjectivities characterized by cycles of rupture and rapprochement in the social and emotional experience of desire and attachment, on the one hand, and indifference and opposition, on the other. Overall, this study of subjectivity and institutions points to the urgency of understanding family dynamics, destabilizing influences, attempts to find meaning, and a recognition of the need for and availability of help among the children and parents/guardians.

Effects of trauma on many ethnic groups
J. David Kinzie

There have been many wars, ethnic conflicts, and even genocide resulting in refugees coming to the U.S. Many refugees now reside in Portland, Oregon, and attend the Intercultural Psychiatric Program. This presentation will describe the characteristics of patients from Bosnia, Somalia, Ethiopia, Iraq, and Farsi-speakers from Iran and Afghanistan. Diagnosis rates of PTSD, depression, and psychosis will be compared. Differences in culture will be discussed.

Trauma, the stressor criterion, and the culture of psychiatry
Allan Young

Every diagnostic classification (disorder) presumes an epistemology, a way of knowing and justifying what constitutes evidence. Questions have been raised about the epistemology of posttraumatic syndromes since their discovery in the 1870s. In psychiatry today, it is widely assumed that questions concerning the epistemology of PTSD are equivalent to questions about the validity of PTSD. In this paper, I argue that the validity of PTSD is a red herring: a distraction from the real issue, namely the heterogeneity of PTSD. Heterogeneity, the fact that diagnosed cases are, in the aggregate, connected through "family resemblances" rather than some shared, intrinsic mechanism. The heterogeneity or PTSD deserves attention because of its practical importance for PTSD research, diagnosis, and treatment. But it has been consistently ignored or misinterpreted, notably in current efforts to perfect the classification's stressor criterion and eliminate the problem of so-called "bracket creep." In this talk, I consider how PTSD is heterogeneous and why this situation may be intractable. The role of culture is considered in two contexts: culture is a source of heterogeneity (the patient's culture) and culture explains the apparent inability of the "trauma community" to recognize PTSD's heterogeneity (the culture of psychiatry).

ABCDE's of working with traumatized refugees
Mark Kinzie & Amela Blekic

Trainees and mental health providers who are inexperienced working with refugees from different cultures are often presented with new and unexpected variations of the clinical encounter. Clinicians are confronted with a complex combination of cultural differences and severe trauma that can result in their own anxiety and confusion. In our presentation, we will present these common themes which can be summarized through the acronym ABCDE. Patients often expect a different level of autonomy and control in decision-making than is typical for Westerners.

Expectation about the boundaries of the clinical relationship and the role of gifts to the clinician can be different as well and as a result play different roles in the assessment and treatment of patients. There are many complexities with regard to the patient's history with multiple traumas, multiple migrations, acculturation difficulties as well as changes to the patients' family structure; the patient's feelings about all these changes are complex as well. Clinicians can react to these complexities with disbelief and negative counter-transference. Finally, there can be differences in the expectations of ending or terminating the case and what constitutes successful treatment. We will explore each of these themes and offer recommendations to improve patient care.

What acculturation teaches about culture
Helgi Eyford

Preliminary findings in an on-going qualitative study of the acculturation of International Medical Graduates (IMGs) to Canadian practice suggest that culture is neither very coherent nor very teachable. IMGs talk about their experience of acculturation not as a smooth journey of progressive competency but rather as a disjointed journey marked by self-doubt and "aha" moments. Findings also reveal that efforts to teach culture in workshops and courses are less helpful to IMGs than are mentors and experience. Culture, it seems, cannot be learned discursively, it must be experienced. These findings challenge the conceptualization of culture that underlies much of the thinking about cultural competency. The idea of competency implies a finite body of knowledge and skills that one can master. Culture is far too complex, relative and contradictory to admit mastery. Drawing upon metaphors first used by Robert Lowie (1920) and Ruth Benedict (1923) but then largely ignored, this paper will argue that culture is best thought of as the shreds and patches of narrative that individuals draw upon to make sense of the world. Health care providers can strive to recognize narratives in themselves and others but this involves intuition more than skill, relationships more than knowledge – in short capacity more than competency. Examples from in-depth interviews with ten IMGs regarding their experiences of acculturation will be used to support this argument.

Common psychotic symptoms, trauma and khat:
Findings from a Somali population from a non-conflict zone
Kamaldeep Bhui

Aim: To investigate the relationship between khat use, and traumatic events, with measures of common psychotic symptoms and symptoms of anxiety and depression in a Somali population in a non-conflict zone.
Method: A secondary analysis of data on a population sample of 180 Somali men and women.
Results: Frequency of khat use was not associated with common psychotic symptoms or with symptoms of anxiety and depression, nor with traumatic events. Traumatic events were related to low levels of psychotic symptoms and high levels of symptoms of anxiety and depression.
Conclusions: Khat use is not inevitably linked to psychotic symptoms in population samples of Somali men and women, but in conflict zones may be used as a coping strategy for trauma and related psychotic symptoms, which might be exacerbated.

Cultural perspectives on mental health literacy among immigrants to the United States
Nora Mulvaney-Day

Increasing levels of mental health literacy among immigrants to the United States requires broadening the approach to consider not just educational content but also the meaning and expression of mental health disorder across cultures. Literacy in mental health cannot be separated from the cultural factors that determine awareness of psychological problems and subsequent need for care. The purpose of this paper is to illustrate the links between mental health problem awareness and labeling of disorders in a low-income group of Latino and Black immigrant patients (n = 20) receiving outpatient mental health care for the first time at a safety net hospital in the US. Videotapes of mental health intakes were analyzed qualitatively for how patients identified and described their mental health concerns and their awareness of having mental health problems. In some cases, awareness of disorder seemed to develop based on tension between the patient's symptoms and certain cultural norms in the US. Patient labeling of the emotional disorder was also linked to prompting from the clinician and prior exposure to mental health concepts. Strategies for developing effective and culturally relevant mental health literacy for immigrant populations in the US are presented, and implications for clinical practice are discussed.

A report on refugees from Burma
Anthony Cull

Burmese citizens have suffered harsh rule by military governments for decades, resulting in civil war and rampant human rights violations, including forced labor and massive displacements. About 140,000 Burmese refugees currently reside in refugee camps on the Thai-Burmese border, administered by the United Nations. Some have spent up to two decades living in these camps. Recent resettlement efforts by Thai and foreign governments have increased the number of migrants from these camps to developed countries, and migration numbers are expected to continue to rise. Using two case examples, I will highlight many facets of the Burmese refugee and immigrant situation that have clinical relevance for diagnosis and treatment, including: conflicts and displacements in Burma leading to migration to refugee camps, conditions of life in the camps and the unique qualities of trauma and other adversities faced by refugees, ethnic variation of Burmese refugees and differences between ethnic groups, challenges faced by the refugees as they resettle in new countries, and issues that may affect treatment of this population of patients.

Cultural consultation services for African immigrants with mental illness
Lonzozou Kpanake

African immigrants in Western countries consult traditional healers on a regular basis when experiencing mental illness. Mental health professionals report therapist-client tensions, misunderstandings, misdiagnoses, repeated failures of treatment, and misuse of mental health services among members of African immigrant communities. This evidence suggests it is necessary for cultural consultation services to integrate traditional consultation practices if their services are to be improved. This paper reviews African healers' consultation practices and why some procedures of these indigenous healers are widely accepted by clients and therapeutically effective. Traditional healers' consultations emphasize: i) involving the patient's family and community members in the process; ii) systematically exploring the patients' relation to spiritual entities including ancestors and nature spirits as objective therapeutic realities; and iii) the

assumption that manipulation of symbols through ritual enactments can lead to long-term healer-patient collaboration, and behavioral and emotional changes. Such traditional consultation practice has been found effective for helping African patients. Cultural consultation services should consider integrating African traditional consultation practices to understand how African patients experience their mental illness and recognize their expectations of therapy.

The limits of cultural competence in the assessment of migrants with psychosis
G. Eric Jarvis

This paper reviewed the clinical presentation of migrants with psychosis and discussed how cultural context influenced the diagnosis and treatment plan. The limits of cultural competence were explored with respect to the management of these cases. The assessments of 11 migrants with psychosis, referred to the Cultural Consultation Service (CCS) in Montreal, Canada, from 2000 to 2010, were reviewed. Cultures of origin of the cases were: Haiti (n = 3), Nigeria (n = 1), Rwanda (n = 1), Congo (n = 1), St. Vincent (n = 1), Kenya (n = 2), Japan (n = 1), and China (n = 1). Culture brokers and/or language interpreters were used in all but one of these. Clinical dilemmas were grouped, categorized, and discussed. Elements of cultural competence were reviewed, and the limits of cultural competence were discussed with respect to the process of cultural consultation described in these cases. Results. Identified clinical dilemmas included: language barrier, culture barrier, misdiagnosis, differing models of illness explanation, racism, family dysfunction due to migration, barriers to mainstream mental health services, and traditional therapies. Specific cultural competence was difficult in the face of tremendous diversity; therefore, the evaluating team sought to be culturally informed when diagnosing and making treatment plans for their patients. When working with culturally diverse patients, such as migrants with psychosis, achieving specific cultural competence may not be possible. Rather, clinicians should seek to be culturally informed about the patients they see through the use of culture brokers and interpreters.

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