Correspondence

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Cultural consultation in psychiatric practice

While Bhui/Sashidharan (2003) raise important questions in the debate on whether there should be separate psychiatric services for ethnic minorities in the UK, a cross-national comparative perspective can shed light on alternative models, which couldvaluably inform British debate (Kirmayer & Minas, 2000). For example, a substantial research literature has arisen in Australia regarding the importance of providing services to minorities in their own languages (e.g. Ziguras et al., 2003). Similarly, in the USA there is an important literature on the effectiveness of services that ethnically match service users and professionals (e.g. Rosenheck et al., 1995). These issues may be fundamental in any encounter between providers and users and deserve the appropriate attention.

The cultural consultation model developed in Canada (Kirmayer et al., 2003) attempts to take into account culture-specific factors to improve diagnostic assessment, treatment planning and case management. The enormous diversity of Canadian society is not captured by the broad ethno-racial categories commonly used in the UK and USA; thus, specialised clinics for each minority group are not feasible. The consultation model does not assume that any clinician can be a ‘fount of all wisdom’, intimately knowing all ethnic, cultural and linguistic groups. The consultation draws on a bank of translators, culture-brokers, anthropologists, religious informants, traditional healers and mental health professionals who can be appropriately assembled to help referring clinicians with assessment and treatment. The aim is to improve the quality of care at all levels of the health care system rather than segregate ethnic groups. Every consultation is an opportunity for in-service training of referring clinicians, with an emphasis on transfer of knowledge. This increases their cultural competence and facilitates collaborative work with culture-specific resources in both the health care system and the community.

Bhui rightly notes that this model, like any other service, will fail without sustained funding. There are also medico-legal issues related to the use of culture-brokers that must be addressed before implementation. However, the model provides an important resource that can promote the appropriate diagnosis and treatment of service-users, while gradually enhancing cultural awareness throughout the health care system.


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Author’s reply: The debate on specialist services for Black and minority groups is a most welcome opportunity to compare and contrast international models of culturally capable services. Whitely, Kirmayer & Jarvis echo the proposal by Waheed et al (2003) that the consultation model established in Canada is to be commended, irrespective of the context in which service models are located. The Canadian approach to diversity in society and in mental health services appears to be more welcoming and supportive in terms of financial investment; furthermore, such an approach endorses the view that specialist rather than separate provision can be useful and is necessary to meet the needs of ethnic minority citizens.

The issue in the UK is that separate funding for special services is rarely available and, as outlined in the original debate (Bhui/Sashidharan, 2003), is ideologically opposed by providers in favour of an integrationist solution. However, this strategy has failed to ensure that generic mental health services are culturally capable or appropriate. Two recent policy documents launched by the Department of Health (2003a,b) attack this issue from quite distinct perspectives, but neither promotes specialist service provision or the consultation model, which, in the UK at least, has often been championed by charismatic and highly motivated clinicians, without the support of sustained investment or a spread of learning throughout the workforce. The first of these policy documents (Inside Outside; Department of Health, 2003a) recommended a cultural capability framework in which a consultation model may have been usefully located but, to date, there is no implementation plan. In some ways these issues are not dissimilar to debates about models of assertive outreach or early intervention, and whether such services are similarly valuable in different cultural and service contexts, irrespective of the transferability of the model. By default, specialist services are being provided in the voluntary sector in the UK; perhaps the consultation model can be commended to policy makers and service providers in the UK as an approach worthy of investment and evaluation. This will need commitment to improve clinical practice skills, and a reorganisation of services, including specialist provision where appropriate.


Dhat syndrome: a functional somatic syndrome?

We read with interest the historical overview on dhat syndrome by Sumathipala et al (2004). We agree with the authors’ contention that categorising it as a culture-bound syndrome is not likely to advance research. The authors examine the nosological significance of this disorder and suggest the possibility of culturally influenced somatoform disorder, although they do not offer a detailed model. In the spirit of Sumathipala et al’s conclusion that there are no absolute truths when it comes to research, the authors examine the nosology of dhat syndrome by Sumathipala et al (2000). We offer to explain these disorders is based on somatosensory amplification, misattribution and abnormal illness behaviour. We have incorporated societal and cultural factors along the lines of the socio-somatic model (Kirmayer & Young, 1998) to explain dhat syndrome as a functional somatic syndrome.

In cultures where open discussion about sexual issues is taboo and fears about masturbation exist, the urogenital system is likely to be the focus of preoccupation. Under stress, persons predisposed to amplification of somatic symptoms and health anxiety may focus attention on physiological changes such as turbidity of urine and tiredness, and misattribute them to loss of semen in the light of widely prevalent health beliefs. These beliefs may then be confirmed by friends and other lay sources as well as by local practitioners subscribing to similar models.

We have recently completed a study showing significantly higher scores on measures of amplification, hypochondriacal beliefs and abnormal illness behaviour in patients with dhat syndrome compared with medical controls. The above model needs to be examined further in both quantitative and qualitative studies. The practical implication of this formulation is that it suggests a viable treatment model based on psychoeducation and culturally informed cognitive–behavioural therapy, which has been demonstrated to be feasible in the Indian subcontinent (Sumathipala et al, 2000).
Cannabis as a psychotropic medication

I considered Arseneault et al’s (2004) search for evidence of the association between cannabis and psychosis as quite skewed. They did not explore the evidence regarding positive, therapeutic or beneficial psychoactive effects of cannabis in mental health in the context of appropriate, rational and clinical usage.

It is now known that the major psychoactive constituent of cannabis and endogenous cannabinoid ligands signal through G-protein-coupled cannabinoid receptors localised to regions of the brain associated with important neurological processes (Iversen, 2003). Signalling, mostly inhibitory, suggests a role for cannabinoids as therapeutic agents in central nervous system disease where inhibition of neurotransmitter release would be beneficial. Evidence suggests that cannabinoids inhibit the neurotransmitter glutamate, counteract oxidative damage to dopaminergic neurons and may be potent neuroprotective agents (Croxford, 2003). These findings open the door to exploration of the physiological role of the anandamide system, and its involvement with mood, memory and cognition, perception, movement, coordination, sleep, thermoregulation, appetite, and immune response. Cannabis users have reported effectiveness of cannabis in relieving aches and pains, fatigue and tiredness, numbing the symptoms of opiate withdrawal, improving sleep, reducing anxiety, and alleviating the vomiting, anorexia, and depression associated with AIDS-related disorders (Robson, 1998). The anxiolytic, hypnotic, appetite-stimulating and antidepressant properties are a compelling reason for research into the use of cannabinoids in psychiatric therapeutics; controlled clinical trials are needed. The role of cannabinoids in modern therapeutics remains uncertain, but there is evidence that it would be irrational not to explore it (Robson, 1998) and, knowing its potent neuroprotective function, its potential role in psychiatric practice should not be discarded lightly.


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One hundred years ago

Medico-Psychological Association of Great Britain and Ireland, Northern and Midland Division

Medico-Psychological Association of Great Britain and Ireland, Northern and Midland Division.—The spring meeting of this society was held on April 7th, at Scalebor Park, Burley-in-Wharfedale, the new asylum erected by the West Riding County Council exclusively for the reception of private patients.—Dr. J. R. Gilmour, the medical superintendent, who was in the chair, read a paper on the Value of Saline Injections in Certain Acute Cases of Mental Disease. His method was first to empty the rectum by an ordinary enema and then to inject 15 ounces of a 0.75 per cent. solution of common salt three or four times daily. Improvement in many cases followed, the mental symptoms quietening and the pulse-rate falling. The injection was rarely returned and no bad effects had been observed. The bladder had to be watched. The treatment was most useful in severe delirious cases where the strength was much reduced.—Dr. Eddison expressed the opinion that the improvement was similar to that occurring in the febrile cases in which restlessness and excitement abated when plenty of fluid was given. In such cases the nervous system shared largely in the benefit produced by the much needed water.

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