

EDITORIAL

Cultural diversity, mental health, and social psychiatry

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

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

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

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

diseases like other medical ones. So, this is considered the first revolution of psychiatry.

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

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

Worth noting are the certain developments in contemporary psychiatry. On one hand, the attempt is to classify psychiatric disorders based on brain pathology (Das 2014). On the other hand, the attempt is to classify treatment according to mechanism instead of category (Talukdar 2014). In between lies the journey of psychiatry from phenomenology to neurocircuitry (Bardhan 2014).

Thus, we asked whether we are entering the phase of fifth revolution in psychiatry (Das et al 2015)!

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

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

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

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

Among the contributions of disorders from India to the world psychiatry, we can name two: dhat and jinjinia, also known as koro.

The jinjinia was first reported by Deepali Dutta and her colleagues from the state of Assam (Dutta et al 1982, Dutta 1983). Later on, there were more such reports from this part to the global platform (Roy et al 2011, Kumar et al 2014).

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

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

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

What Kieling et al (2009) observed that among the psychiatric journals indexed in major international bibliographic databases like that of Web of Science and Medline (Clarivate Analytics 2017, U.S. National Library of Medicine 2016), only 4.1% such journals are from LAMIC. Rest all are from high income countries. Mari et al (2010) called it "the 5/95 gap"! Authors stated that difficulties arise

in achieving fair representation as a result for scientific production's literature database. They highlighted the rarity of journals that have LAMIC focus as a major obstacle in disseminating research related to LAMIC.

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

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

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

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