Message from the President

Andrew Cheng

Dear IFPE members:

The preparation of our 11th Congress to be held in May 2007 in Goteborg, Sweden has been on the way. The IFPE Executive and our host Professor Ingmar Skoog are working closely on this. The first announcement of the Congress is now available from both the Congress home page (www.congrex.se/ifpe2007) and the IFPE homepage (www.sinica.edu.tw/~ifpe). The former will be updated from time to time, and you can link to it from the latter and vise versa.

Please mark the Congress dates on your diary now, and start to prepare your best work for presentation. The main theme of this Congress is “Globalisation and changing patterns of mental disorders across the life span”, and research reports from any aspect of psychiatric epidemiology, including clinical epidemiology, service evaluation and longitudinal studies, will be welcomed as always by the Scientific Programme Committee. You are welcome to organise interesting seminars for submission in due course. Please do not forget to forward the first announcement to your colleagues who may be interested to attend the Congress.

Our bulletin has always welcomed short (two-page) articles on research work, review articles or editorials from our members. Please send your articles to the bulletin Editor Dr Heather Stuart at any time, together with a brief autobiography.

All best wishes for 2006

Update from Buenos Aires

Edith Serfaty
Committee Member, IFPE

International Conference on Mental Health Epidemiology was held in Buenos Aires, Argentina, March 10-11, 2005. This conference was sponsored by The International Federation on Psychiatric Epidemiology, Argentinian Association of Psychiatry (AAP) and Asociacion Medica Argentina. Honorary Presidents: Prof. Abraam Sonis and Prof. Jorge Insua. Dr. Edith Serfaty, from Centro de Investigaciones Epidemiologicas (Center for Epidemiological Research), Academy of Medicine, chaired the Conference.

Lectures and round tables were held jointly with The Argentine Psychiatrists' Association under the auspices of the International Federation of Psychiatry Epidemiology, and the Moyano
Memorial Unit, School of Psychiatry, Universidad de Buenos Aires (The Federal University of Buenos Aires). During the opening ceremony, both Dr. Serfaty, and Dr. Alberto Monchablon (AAP) explained the rationale of the central conference topic and details thereof. Prof. Duncan Pedersen, and Prof. Raymond Tempier were the keynote speakers. Prof. Pedersen, an anthropologist physician at the McGill University of Montreal, Canada, lectured on violence research currently conducted in Peru. Prof. Tempier, consultant of the Psychiatry Department of the Montreal General Hospital (now Head of the Department of Psychiatry, Saskatoon, Saskatchewan) lectured on mental health research conducted in Canada.

The different topics included: Violence linked to Affective Disorders (Prof. Andrea Lopez-Mato); Anxiety Disorders (Dr. Alfredo Cia, and Dr. Miguel Marquez); ADD (Dr. Roberto Yunes); Schizophrenia (Dr. Marcelo Cetkovik). Dr. Paulo Menezes, Dr. Maria Scafuzza, and Dr. Darci Neves, from Brazil, informed on both the social aspects of violence, and research on violence currently carried in their country. Prof. Suarez-Richard, Universidad Nacional de La Plata (The Federal University of La Plata) lectured on violence and mental health, and relationship thereof with health primary care.

The closing round table conclusions were that violence, and violent crimes are observed more frequently in unfavourable economic situations, related to multiple personal, family, and environmental factors. Setting up limits to violence is just preventing community-aimed violent crimes. Many thanks to Lab.Gador SA and Glaxo Smith Klein for their support.

CAPE’s membership is multi-disciplinary and owing to increased federal funding for training programs in mental health, we have seen a growing cadre of PhD and Masters students attend each year. This year’s annual CAPE Scientific Symposium was held in Vancouver, November 3, 2005 and co-sponsored by Simon Fraser University. Psychiatric epidemiology has been receiving increasing attention in Canada, since Statistics Canada undertook a national mental health survey focusing on the prevalence of major mental disorders and mental health utilization among Canadians. CAPE members were instrumental in the design of this survey and, through a series of funded proposals, have now taken national leadership in analyzing the results. A significant part of the CAPE conference (both this year and last) was spent in discussing the results of Canada’s Community Mental Health Survey—both the substantive results as well as the where do we go from here discussions. Statistics Canada is planning another survey so results from these meetings could have a significant role to play in the shaping and execution of this second important national sample. Paper and poster presentations covered the full gamut of topics, ranging from the prevalence and risk factors for social phobia; to co-occurring problem gambling, mental illness, and substance abuse; the impact of antidepressant warnings on prescribing trends, the social ecology of schizophrenia, and psychosis and access to mental health services; to name just a few. The day closed with a dinner at a local restaurant and the presentation of the Alex Leighton Award. This is a joint award offered by CAPE and the Canadian Psychiatric Association. This year’s Alex Leighton Award recipient was Dr. Nick Kates in recognition for his national and international contributions to psychiatric epidemiology, particularly with respect to shared care.

Update from Canada

Julio Arboleda-Flórez, MD, PhD
President, CAPE

The Canadian Academy of Psychiatric Epidemiology (CAPE) counts between 40 and 50 members and hold a yearly annual conference one day prior to the Canadian Psychiatric Association.
Psychiatric epidemiology has for a long time played an important role in the Danish scientific world. Denmark is famous for its' many registers that enable countless research possibilities. Denmark has a scientific society for psychiatric epidemiology called DSPE (Danish Society for Psychiatric Epidemiology). Their web site can be visited at www.dspe.dk.

DSPE organises scientific meetings several times a year with both national and international speakers. The society has this year also arranged a course in epidemiological methodology. DSPE has around 80 members. The DSPE Board consists of active researchers within psychiatric epidemiology as well as clinicians. This mix ensures the combination of scientific high quality and daily clinical problems and challenges; hence DSPE meetings are always very popular events.

The president of DSPE is Dr. Hans Moerch-Jensen, Rigshospitalet, Copenhagen. DSPE has a strong connection to the Nordic Association for Psychiatric Epidemiology (NAPE). NAPE has members in Iceland, Sweden, Norway, Finland and Denmark. NAPE’s president is Dr. Christina Hultmann at Karolinska Institute in Sweden. NAPE has one annual meeting that this year took place in Copenhagen. The topic was the link between psychopharmacology and epidemiology and was quite a success. NAPE’s web page can be visited at www.nape.dk.

Culturally Specific Symptoms & Stigma in Depression. A Romanian Perspective.

Alina Martin, Toronto, Canada
(alina5mar@yahoo.ca)

Depression, one of the most frequent mental disorders on the planet, still needs clarification of the nature of its symptoms. Situated at the crossroad of mental health, psychology, and sociology, the mostly heterogeneous category generically called depression, is neither completely understood, nor satisfactorily classified. Historical attempts to delineate the priority of the brain dysfunction versus the psychosocial determinants in the development of depressive states have failed, so far. A new perspective, which takes into consideration the role of the social disapproval in the genesis of some cultural specific symptoms in depression, is brought into discussion.

Cross-Cultural Perspectives on the Clinical Picture in Depression

It has been hypothesized that depressive clinical picture might be influenced by culturally specific features and change along with certain cultural traits. Cross-cultural studies aim to establish the real incidence of depression in different cultures and to differentiate between culturally specific symptoms and universals. In a WHO coordinated collaborative study a “core” of universal symptoms of depression were identified in the majority of the patients from five research centres (Jablensky et al., 1981). Nevertheless, evidence shows that the affective distress may also be differently expressed in various cultures.

If we do understand depression along with Kaestner (1947) as a loss of feeling for values (in German “das Wertfühlen”), depressive patients are expected to present symptoms expressing their limitation in adapting to internalised cultural values and norms. Kroeber and Kluckhohn (1952) stated that the alternatives which exist for dealing with problems are actually limited and concomitantly present in all societies at all times, the profile of dominant cultural norms and their
variations being given by the rank-ordering preference for some of these alternatives. With this hypothesis, societies rely on limited alternatives to express social distress related to depression.

Culturally specific symptoms in affective distress might be determined by the interpersonal context of the community and the extent to which the failure toward the group values and norms would be stigmatized by the society. Previous cross-cultural research has already stressed that in some cultures bodily complaints offer a socially less disadvantageous alternative to the less accepted emotional experiences (Raguram et al., 1996). Other culturally specific symptoms, such as the Whakama concept in indigenous Polinesian people of New Zealand (Sachdev, 1990) include a very important interpersonal context in which failure towards the group values and norms is central.

Further debates regard the cultural specificity of the symptoms emerging from the responsibility of decision-making, more or less shared with the social group. Radford (1991) found indecision more frequently in the Australian than in the Japanese depressive patients, who belong to a collectivist society where the responsibility of decision-making is shared with the social group. Hypochondriac ideas have often been reported as culturally influenced (Robbins & Kirmayer, 1991), emerging from differences in causal attribution dimensions and help-seeking attitudes.

We do understand the concepts of Individualism and Collectivism as “the extent to which individuals are integrated into groups” according to Hofstede and Peterson (2000). The stigma of failing to fulfill other people’s expectancies should be expected to be more significant in collectivist cultures. These cultures control their members through external societal pressure: shame (members place importance on fitting in harmoniously and saving face), whereas individualistic cultures control individuals through internal pressure: guilt (members place more emphasis on self-esteem) (Adler, 1991).

Culturally Specific Symptoms in a Romanian Sample of Patients with Depression

In a study conducted on urban depressive patients living in Romania, we found all the depressive core symptoms reported by Jablensky et al. in 1981, and some specific symptoms, which are relevant for their connectedness with the stigma felt by depressives in this culture (Marin et al. 2005). The sample consisted of 50 patients who fulfilled the ICD-10 diagnostic criteria for Affective Diseases with the present episode depressive (F: 31.0; 31.3, 32; 33). A control group consisting of 33 randomly assigned healthy people has also been taken into consideration. Several international self-rating instruments such as the Beck Depression Inventory (BDI), Self-Rating Questionnaire (SRQ), Hopkins Symptom Checklist (SCL-90-R) as well as a culturally specific scale, the Romanian Depression Questionnaire (RDQ) have been applied. For the patients only, the Hamilton Depression Rating Scale (HDRS 17 items) was also used. The frequency of each symptom within the groups has been calculated.

The Romanian depressives over-scored specific symptoms expressing their disability to participate to the social life: deficiency in problem solving, lack of social efficiency and fear to loose support. This makes much sense in the Romanian culture, prone towards collectivist values and with a high social cohesion, where the patients felt incompetent and vulnerable to social disapproval. In such cultures, where emotional cohesion and closeness are highly valued, the social dysfunction generated by depression might shift the interaction burden onto non-depressed family members. Subjective tiredness, loss of vigour, fatigability, retardation and work inhibition frequently complained by the Romanian depressives, might be regarded as an expression of help seeking in an emotionally enmeshed culture. Somatic complains were rare, since speaking about emotional matters is culturally approved. Nevertheless, hypochondria was frequently rated by the Romanian patients. We suggest that hypochondria should also be understood from the perspective of social stigma: these patients worry about feeling incompetent and switch the causal attribution of the lack of social ability, seeking help and a way to escape the social disapproval for
not being socially efficient and not being able to solve the problems, which would in turn lead to loosing social support.

Unlike for other societies oriented toward the group’s values, indecisiveness was frequent in Romanian patients, since the community expects members to be able to make their own decisions. The lack of ability to make decision in the depressive context is stigmatized by the social group and thus frequently complained by the patients.

As expected for a collectivist society that controls her members through shame rather than through internal pressure, guilt feelings were also rare. Suspiciousness and paranoid symptoms were rare. Along with Hafner, Binitie and Keegstra, we attribute these findings to a less competitive living style in this culture. Failing to be competitive is not stigmatized in this culture.

Conclusions:

The analysis of cultural influences on depressive symptoms can promote a better understanding of depressive illnesses. The study conducted on Romanian patients reveals a serious influence of the social emotional cohesion and cultural norms on the depressive clinical picture. Most of the depressive patients feel socially ineffective and seek for help by displaying tiredness and hypochondriac symptoms, in order to balance the stigma. Trying to maintain homeostasis and cope with the social disapproval triggered by the depressive illness, families tend to increase cohesion. Therefore, dysfunctional circuits that disable the patient’s recovery could be established in families, where raising the family tendency towards fusion would lower the functional level of differentiation (Kerr & Bowen, 1988) and make the patient less competent. Psychotherapeutic approaches for depressive patients should identify maintaining factors for dysfunctional circuits and offer a better support for individual growth and maturation by taking into consideration specific cultural values. Social programs that aim to destigmatize depression and support people to rehabilitate into society would also improve recovery.

References:


In Memory

Dr. Morton Birnbaum passed away on November 26, at Cabrini Medical Centre at 79 years of age. Dr. Birnbaum was both a physician and a lawyer and a staunch legal advocate and fighter for expanded rights for the mentally ill, including the federal standards governing the right to treatment and the legal right not to be confined involuntarily if not a threat.

Calendar of Events

Nice, France, March 4-8, 2006

The theme of the 14th European Congress of Psychiatry is Exploring Science and Serving Citizens. The preliminary programme may be viewed online: http://www.kenes.com/aep2006/prog.asp
The Congress Secretariat may be reached at: Kenes International, 17 Rue du cendrier, P.O. Box 1726, CH-1211 Geneva 1, Switzerland, Tel: +41 22 908 0488, Fax: +41 22 7322850 E-mail: aep2006@kenes.com

Madrid, Spain April 20-23, 2006

WPA Thematic Conference organized by the Lopez-Ibor Foundation. Contact: Dr. Juan J. Lopez Ibor Jr., email: lji@lopez-ibor.com

Bordeaux, France, June 14-17, 2006

13th European Symposium, organized by the Section Epidemiology and Social Psychiatry of the Association of European Psychiatrists. The theme of the Symposium will be Prevention and Treatment of Psychiatric Disorders. Website: http://www.aep-epidemiology2006.fr/

Seattle, Washington, June 21-24, 2006


Istanbul, Turkey July 12-16, 2006

Psychiatry: Uniqueness and Universality. World Psychiatric Association International Congress, in collaboration with the Psychiatric Association of Turkey and the Turkish Neuropsychiatric Society. Website: www.wpa2006istanbul.org

Istanbul, Turkey October 5-8, 2006

3rd International Conference, “Together Against Stigma” is sponsored by the WPA Program to Fight Stigma and Discrimination because of Schizophrenia. The theme of the conference will
be “A Decade of Progress.” The conference will offer an opportunity to present new data from programmes against stigma and discrimination because of mental illness from many countries including the nineteen countries that are brought together by the WPA programme against stigma. In addition the conference will, for the first time, provide opportunities to present material concerning stigma due to illnesses other than schizophrenia and to specified population groups such as the refugees. Website: www.stigmaistanbul.org.

**Melbourne, Australia, November 28-December 2, 2007**

Working Together for Mental Health: Partnerships for Policy and Practice. A World Psychiatric Association International Congress co-sponsored by the Royal Australian and New Zealand College of Psychiatrists. For more details see: www.wpa2007melbourne.com

**Prauge, Czech Republic September 20-25, 2008**


**From the Editor…**

The IFPE Bulletin is published twice yearly. We would like to hear from you. Tell us about your latest research in progress, something about your research group (with pictures of course!) or something about epidemiology or mental health developments in your country. Submissions can be short (1,000 to 1,500 words). Also consider letting us know about regional meetings and congresses or other local activities that may be of interest to epidemiologists. If you would like to contribute to the Bulletin, send me an email at hh11@post.queensu.ca.

I hope everyone had a happy Christmas and extend my wishes for a prosperous new year.

-Heather Stuart, Queen’s University, Canada