Oral

Thu. Sep 25, 2025 6:00 PM - 7:00 PM JST | Thu. Sep 25, 2025 9:00 AM - 10:00 AM UTC Session Room 4 (Large Hall B)

Oral 4

[O-4-01]

Re-visiting the Transcultural Clinical Consultation Service - Two decades on...

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[O-4-02]

Demographic and sociocultural specificity of populations and mental disorders

*Svetlana V. Vladimirova[1], Nikolay A. Bokhan[1], Igor A. Artemyev[1] (1. Mental Health Research Institute (Russia))

[O-4-03]

Patterns of Psychiatric disorders, self-reported psychological well-being and distress and their social and clinical correlates, in individuals attending an urban mental health clinic, in Bangalore, a metro city of India- A retrospective chart review

*NIRMALYA MUKHERJEE[1], Sundarnag Ganjekar[2], Senthil Kumar Reddy[2], Gargi Mondal[1], Harish T[2] (1. East West Institute of Medical Sciences and Research (India), 2. NIMHANS, Bangalore (India))

[O-4-04]

Cultural Explanatory Models of Mental Illness in Southeast Asia and Their Impact on Help Seeking and Clinical Practice: A Systematic Review

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[O-4-01] Re-visiting the Transcultural Clinical Consultation Service - Two decades on...

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Keywords：Cultural Formulation、Consultation-Liaison Psychiatry、Mental Health Services

Background:
People from a Culturally and Linguistically Diverse (CALD) background have diverse needs and understandings of mental illness. The cultural consultation model is a valuable way of supporting mental health service provision for this population. This model was initially outlined by the Cultural Consultation Service two decades ago in Montreal, Canada. In Queensland, the Transcultural Clinical Consultation Service (TCCS) utilises the services of Cultural Consultants and operates on a consultation-liaison basis.

Objectives:
To report on the nature of cultural consultations seen through the TCCS.

Methods:
Detailed records were kept on all cultural consultations between February 2021 to February 2023. Data collected included demographic data, referral sources, referral questions, use of Cultural Consultants and/or language interpreters, cultural formulation and referral outcomes. A qualitative thematic analysis on the cultural consultations was performed.

Findings:
Over this time period, sixty-one cultural consultations were performed by the Psychiatrist. Most were primary consultations. The process of cultural consultation was typically time- and labour-intensive, as there was a need to address multiple aspects of a patient's presentation. The consultations could broadly be classified into: Those seeking practical support/appropriate referral options (which sometimes could not be addressed), and Addressing the impact of cultural diversity on mental health problems. This presentation will focus on the met and unmet needs of this group.

Conclusions:
Culture is a critical component in the manifestation of mental ill health and while Cultural Consultants can be important in helping to understand such issues, this study highlights that there are many unmet needs in this area.

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[O-4-02] Demographic and sociocultural specificity of populations and mental disorders

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Keywords：Cultural psychiatry、urban populations、mental disorders

Introduction: In the Russian Federation, urban populations have historically formed that are unique in demographic, socio-cultural and other parameters.**Objectives:** to determine the nosological profile of mental disorders by major taxa - psychotic disorders and schizophrenia, mental retardation and the entire pool of borderline neuropsychiatric diseases in three cities - in Surgut, an intensively developed region of the Tyumen North, in Petropavlovsk-Kamchatsky (Far East), which we attribute to the formed, traditional urban populations, in Kyzyl as the center of an autochthonous territory with a high level of indigenous population.**Methods:** statistical information on patients registered in psychiatric institutions.**Results:** Surgut has the lowest number of patients with psychotic disorders 38.6 ± 1.5%, which is 1.6 times lower than in Petropavlovsk-Kamchatsky 62.4 ± 1.1% ($P < 0.05$). The proportion of patients with mental retardation in Kyzyl is 34.2 ± 1.2%, which exceeds the figures both in Petropavlovsk-Kamchatsky 12.0 ± 0.8% and in Surgut 18.6 ± 1.2%, i.e. in Kyzyl 80% are people with psychotic disorders and mental retardation, and borderline neuropsychiatric diseases make up 20 ± 1.1%; in Surgut, the opposite picture is observed: the latter - 42.7 ± 1.6%. In Petropavlovsk-Kamchatsky, the proportion of mental retardation is lower than in other populations - 12.0 ± 0.8%.**Conclusions:** Thus, the structure of registered diseases in the three urban populations is different: in the flowing population, neurotic disorders due to migration pressure prevail; in the traditional population, mental disorders and schizophrenia prevail, which may be associated with the accumulation of patients in long-standing groups; in the autochthonous population - with traditional tolerance to behavioral disorders of endogenous and exogenous origin and family structure - patients with mental retardation.

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[O-4-03] Patterns of Psychiatric disorders, self-reported psychological well-being and distress and their social and clinical correlates, in individuals attending an urban mental health clinic, in Bangalore, a metro city of India- A retrospective chart review

*NIRMALYA MUKHERJEE[1], Sundarnag Ganjekar[2], Senthil Kumar Reddy[2], Gargi Mondal[1], Harish T[2] (1. East West Institute of Medical Sciences and Research (India), 2. NIMHANS, Bangalore (India))

Keywords：community psychiatry、urban mental health clinic、psychiatric morbidity、distress、wellbeing

Background: Rapid urbanisation and migration from rural to urban areas widen the treatment gap in the urban population with mental health care needs. People generally prefer psychiatric clinics over hospitals, because of accessibility and less stigma. Community-based centres facilitate easier access and comprehensive care. Clinic-based data aid in service planning and resource allocation. In this area, data from the Indian context is limited. Therefore, we planned this study.
Objectives: To examine the pattern of psychiatric morbidity and its correlates in persons attending an urban mental health clinic. **Method:** Following approval from the institutional ethics committee, the case-record files of individuals attending an urban mental health clinic in Bangalore, India, from April 2018 to March 2019, were reviewed retrospectively. We collected sociodemographic and clinical information, including the WHO-5 well-being index and K10 assessment scores, which were recorded routinely at baseline. Descriptive, correlational, and multinomial regression analyses were performed using SPSS version 21.
Results: Out of 195 case-records, the majority had depression (n=70, 35.9%), followed by anxiety disorders, including OCD (n=36, 18.5%), and trauma-related disorders (n=35, 17.9%). Most patients reported significant distress (82%) and lower well-being (70.3%). Distress was higher among females, depressed individuals, those not currently married, and those with a family history of psychiatric illness. Additionally, well-being was poorer in individuals with recurrent psychiatric illness.
Discussion: Urban mental health wellbeing clinics probably serve people with common mental illnesses. Besides psychiatric morbidity, gender, marital status, and family history of psychiatric illness also contribute to distress and poor well-being. These highlight the need to build more such clinics for the general population, as individuals with common mental illnesses find it difficult to access psychiatric hospitals. Future prospective studies should explore how gender, marital relationships, familial tendencies, and recurrent psychiatric illnesses influence well-being and perceived distress in people with common mental illnesses.

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[O-4-04] Cultural Explanatory Models of Mental Illness in Southeast Asia and Their Impact on Help Seeking and Clinical Practice: A Systematic Review

*Charlotte Alyssia Jonatan[1], Claudya Hadilianti[1], Darien Alfa Cipta[1,2] (1. Department of Medicine, Universitas Pelita Harapan, Tangerang (Indonesia), 2. Department of Psychiatry, Siloam Hospitals Lippo Village, Tangerang (Indonesia))

Keywords：Cultural Explanatory Models、Help-Seeking Behavior、Mental Health in South-East Asia

Background:
Cultural explanatory models rooted in spiritual, supernatural, and psychosocial worldviews remain highly influential in Southeast Asia. These models shape how individuals interpret mental health symptoms, often guiding help-seeking behavior and impacting stigma, diagnosis, and service engagement. As a result, they contribute to treatment delays, misdiagnosis, and underutilization of psychiatric care.

Objective:
This review aimed to systematically examine the dominant cultural explanatory models of mental illness across Southeast Asia and assess their influence on help-seeking behavior, stigma, and clinical practice outcomes.

Methods:
This review analyzed 16 peer-reviewed studies using qualitative, cross-sectional, and mixed-method designs across Southeast Asia. Studied populations included ethnic minorities, religious leaders, healthcare providers, and community members. The review examined dominant explanatory models, help-seeking pathways, and clinical implications in conditions such as depression, schizophrenia, anxiety, and perinatal disorders.

Results:
Supernatural and spiritual explanations were predominant. In Malaysia, mental illness was attributed to witchcraft, black magic, spirit possession, and loss of *"semangat"*. Indonesian beliefs centered on *jinn*, curses, and energy imbalance. Vietnamese and Cambodian views emphasized karma, ghost-related causes, and spiritual loss, while Thai models integrated Buddhist ideas of merit and karmic debt. Help-seeking followed a pluralistic, staged process beginning with family, traditional, or religious healers, and later biomedical services leading to delays, misdiagnosis, and reduced treatment adherence. Rural communities exhibited stronger reliance on traditional models and faced greater access barriers.

Discussion:
Cultural models significantly influence mental illness recognition, stigma, and clinical

engagement in Southeast Asia. Individuals often prioritize traditional and spiritual care before accessing psychiatric services. These findings underscore the need for culturally adapted diagnostic practices, community-informed psychoeducation, and clinician training in culturally responsive care. Aligning psychiatric services with local belief systems through policy initiatives and cross-sector collaboration, including with traditional and religious healers could improve help-seeking, diagnostic accuracy, and long-term mental health outcomes.