On the Path to Mental Health in the Andes

Reflections from a Psychiatry Elective in Urban and Rural Peru

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Arrival in Peru and Overview of Comisión de Salud Mental de Ayacucho (COSMA)

I arrived in Ayacucho, Peru on a Monday morning in January 2012 shortly after completing a three-week general medicine elective in a small clinic in southern Ecuador. I was set to begin a six-week psychiatry elective, observing and participating in patient encounters in mental health clinics and hospitals in both the Andean city of Ayacucho and Lima, Peru's capital. Providing supervised medical care to patients in Ecuador had exposed me to some of the health issues commonly faced by a rural Andean population of farmers or campesinos, as well as the challenges of working in low-resource settings. Patients largely reported ailments related to a lifetime of hard physical labor, such as back and joint pain, and were also treated for a range of common medical conditions, including hypertension and acid reflux. Occasionally, my supervising doctor commented that he suspected some patients' physical symptoms reflected elements of "somatization," the embodiment of mental distress. Having studied medical anthropology prior to medical school, I was familiar with this phenomenon and other "local idioms of distress," or the "particular ways in which members of sociocultural groups convey affliction."[1] However, in this busy medical clinic, there was rarely time to meaningfully explore the etiologies of such complaints with patients.

Deeply interested in further exploring how health and experience are shaped by complex interactions between social, cultural, political and economic factors, I sensed the unique nature of the opportunity to work in Ayacucho, a city that simultaneously epitomizes the beauty of the Andes and embodies the region's darker history of political violence and economic oppression. Strongly considering a career in global mental health, I was curious to learn about the models of mental health care being employed in the clinics and hospitals I would encounter and the ways they were addressing the astonishing treatment gap that characterizes this field. Currently, more than three-quarters of individuals with serious cases of mental illness in less developed countries do not receive adequate treatment.[2] The great challenge for the field of global mental health is to address this "moral failure of humanity" in contextually appropriate ways that promote human rights and avoid detrimentally imposing Western systems of diagnosis and treatment.[3]

Jordan Sloshower

The existence of the Comisión de Salud Mental de Ayacucho (COSMA), the region's only functioning mental health clinic, is predicated on Ayacucho being not only "an impoverished area with no available psychiatric care" but also "the cradle of the Shining Path terrorist movement in the 1980s and 90s [that] had suffered massive trauma from the terrorists and government counter-insurgency."[4] Briefly, Ayacucho had been the birthplace of the Sendero Luminoso (Shining Path), a Maoist revolutionary "terrorist" organization that sought to dismantle the country's political establishment through guerilla warfare. This uprising sparked a violent civil war that resulted in the deaths and disappearances of approximately 70,000 people, mostly innocent rural campesinos.[5] Displaced persons numbered 430,075, the majority of whom were from Ayacucho.[6] Being the unfortunate epicenter of the violence, Ayacucho is an ideal location to study the effects of political violence and poverty on health and wellbeing.

This history is firmly reflected in COSMA's mission statement, which is currently translated as follows:

> "We are a nonprofit Civil Association serving the mental health needs of the people, with priority given to the most vulnerable people in the region of Ayacucho, especially those affected by sociopolitical violence that has resulted in physical, psychological and emotional sequelae. We seek active participation of the individual, family and community to contribute to social development, with full respect for human rights and maintenance of a culture of peace."

While this commitment to addressing the health and psychosocial consequences of political violence in the region has been present since COSMA's inception, almost all other facets of the clinic have changed over time. Since Sister Anne Carbon, a Filipina nun and trained psychiatric nurse, started the clinic in 2003 "with minimal supplies, volunteer nursing staff, and a volunteer psychiatrist" from Lima,[4] the staff of nurses and psychologists has gradually grown, and more psychiatrists and psychiatric residents from Lima now visit the clinic each month. Although the clinic remains without any permanent psychiatrists on staff, this expansion of personnel represents a great improvement over the situation in 2004, when the entire Ayacucho department had only one psychologist and no psychiatrists.[6] This dearth of mental health care is part of a general lack of public health infrastructure in the Ayacucho region, characterized by "limited access to medicines,

emergency health care and other health care services."[6]

Approximately five years ago, COSMA moved to its current location, discreetly situated amongst residential complexes and local eateries on an inconspicuous street at the bottom of a hill in southern Ayacucho. Passing through the clinic's unmarked wooden door reveals a bright, open-air complex with clean tiled floors and walls painted with mountain scenery and complex designs of traditional Andean tapestries. The multi-level clinic contains treatment areas, offices, a pharmacy, an occupational therapy room with looms and an apartment where I lived with Brother Jimi, the clinic director.

Interestingly, the clinic's directorship was transferred in January 2011 to the Brothers of Charity, "an organization with Christian values, whose vision is to provide services which support people's individuality, choice, rights and dreams."[7] Under the Brothers of Charity, the clinic has remained non-sectarian, attempted to adopt a more community-based model of care, increased the number of trained psychologists and social workers on staff and designated specific clinical personnel to address substance abuse problems. The volunteer psychiatrists that visited the clinic during my stay agreed that COSMA's increased provider recruitment and shift toward community-based care represented positive steps for addressing the "high rates of mental health problems …among the highland Quechua populations exposed to violence-related stressors."[8]

Clinical services at COSMA are currently provided through three main departments. The clinical department, consisting of psychologists, nurses, a social worker, a pharmacist and visiting psychiatrists, is tasked with treating patients with a variety of mental health disorders in the clinic and in their homes. Medications are made available to patients through a tiered pricing system, in which the cost to the patient is determined in consultation with a social worker. In response to my concern that this policy may deter utilization by the poorest of the poor, Brother Jimi reassured me that treatment is routinely provided for free to those unable to contribute. In fact, he stated that income from patients only covers 8% of the clinic's operating costs and that the shift away from providing universal free care reflects the Brothers of Charity's desire to make their clinical programs more sustainable. The only negative impact of this policy I could detect was some confusion amongst the visiting psychiatrists about whether and to what degree cost considerations needed to be factored into their prescribing practices. Frequently, we would walk over to the in-house pharmacy to discuss price differences between medicines and creative strategies to lower costs, such as crushing pills and encapsulating the medicines in personalized doses.

The second clinical service at COSMA is a rehabilitation department that runs a day program for patients with chronic schizophrenia, who seemed to compose a large proportion of the clinic's long-term patients. The program, which complements their psychiatric care, involves three steps: functional rehabilitation (cognitive rehabilitation, physical rehabilitation and basic skill building) to give patients control of their lives; psychosocial rehabilitation to integrate patients back into their families and local communities; and occupational rehabilitation, through which patients learn income-generating skills, such as how to produce a range of handicrafts. Finally, there is a half-day program for children, adolescents and adults with mental disabilities. This program focuses on behavior modification, developing learning abilities and alternative communication. Overall, it was clear that the clinic had made significant strides since 2003 and was now better able to provide multi-faceted treatment programs to meet patients' often-complex needs.

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My Experience at COSMA

I spent my first half-day at the clinic working with the triage nurse, who performs initial interviews with new patients and decides which departments and providers the patient will see. Generally, patients are assigned to either psychiatry or psychology, and almost all patients are referred to the social worker to discuss the cost of service and medicine, as well as other potential barriers to care. Observing this intake process provided a useful overview of patient flow at COSMA, into which I was thrust the next day upon the arrival of two American psychiatrists affiliated with the Peruvian-American Medical Society (PAMS).

During our orientation meeting with Brother Jimi, a clinic nurse suddenly entered the room and requested that one of the visiting American psychiatrists attend to a young girl in distress. I joined the doctor and evaluated my first psychiatric patient in Peru: a 12-year-old girl with shiny black hair and deep, distant brown eyes. Her father reported that for weeks she had remained in isolation, crying and "hearing voices" that frightened her. Strikingly, the girl told us that she did not feel like herself anymore. The doctor and I suspected an early psychotic break and started her on a low dose of the antipsychotic medication olanzapine. The following morning, we visited the patient in her home to monitor her response to treatment. She reported having slept fairly well and some nondescript symptom improvement but commented disconcertingly that the medicine made her feel even less like herself. Given the absence of overt medication side effects, we reassured the girl's parents, explained the plan to slowly increase her dose to therapeutic levels and returned to the clinic.

Although I knew my time in Peru would hold numerous surprises, this introduction to the elective felt unexpected and unsettling. I wondered how many young people with psychotic disorders there were in Ayacucho and whether the benefits of treating a young girl with powerful antipsychotic medications would outweigh the adverse effects of sedation, metabolic disturbances and movement disorders. I was also uncertain of how starting her on this treatment at such an early age would impact her developmental trajectory and what more could be done at family, community and societal levels to achieve a positive long-term outcome. Having had such a striking initial patient encounter, I was highly intrigued to meet more patients and discover what other mental forms of mental illness I would encounter in this picturesque but poverty-ridden mountain city.

During the five days that followed, I worked primarily with a visiting psychiatrist from Lima who completed his residency in New York City and a fellowship in addiction psychiatry at Yale. Together, we spent a half-day working at the local asilo de ancianos (nursing home) and saw follow-up patients at COSMA. Working at the nursing home was a unique opportunity that presented a number of interesting challenges related to providing mental health care in a low-resource setting. The psychiatrist and I saw a large number of elderly patients, many of whom maintained a traditional Andean style of dress, in a short amount of time. Little background information was known about a number of patients, who had either been dropped off by their families or had come in off the street. Moreover, translation difficulties and patients' physical and mental disabilities made it difficult to gather new information. This lack of a complete clinical picture was complicated by the practice of keeping psychiatric and medical records separate, as is done in many psychiatric facilities around the world. I often found myself wishing I could see what medical diagnoses and treatments patients had received.

Given those limitations, our evaluations primarily entailed adjusting patients' medications based on what we could observe and what the sisters working at the asilo reported about their recent behavior and function. Other challenges we encountered resulted from the reality that the nursing home relies on the donated services of various psychiatrists who come from Lima each month. It was often not entirely clear why certain medications had been started or why dosages had been adjusted, thereby making it difficult to follow the effects of a given prescription. This lack of a detailed diagnostic record tends to deter discontinuing or decreasing medications, which could in theory lead to "polypharmacy," or overmedication. Although I found myself wishing we could perform more in-depth evaluations and learn more about these patients' lives and medical histories, I left feeling reassured that the visiting clinicians were doing the best they could under very difficult circumstances. By helping regulate patients' sleep and appetites, avoiding the need for physical restraints in patients with agitation and generally maximizing patients' ability to perform activities of daily living, psychiatric care was helping the asilo residents live the remainder of their days with dignity.

In the more traditional clinic setting at COSMA, circumstances were rather different. Patients had more thoroughly documented medical histories, and we were able to conduct interviews in the presence of family members as well as psychiatric nurses capable of translating Quechua in order to fill in gaps of information. The psychiatrists and I primarily saw patients who had been diagnosed with psychotic disorders, mood disorders and substance use disorders. A striking but perhaps unsurprising feature of COSMA's patient population, given Ayacucho's history of violence and ongoing poverty, was the relatively large numbers of patients suffering from the last. The majority of these patients were abusing alcohol, marijuana and/or pasta básica de cocaína (PBC), a cheaper, more addictive form of cocaine. Increased rates of alcohol and substance abuse are known to occur in the wake of political violence, and villagers from Ayacucho have reported a rise in alcoholism, mostly among men, and increased alcohol abuse during fiestas since the civil war.[6] The relationship between exposure to political violence and mental health is also reflected in the results of a 2008 epidemiologic survey from the rural Sierra regions of Peru that found an annual prevalence of harmful or dependent alcohol use of 3.6% in those who lost a family member during the war versus 1.3% in those who did not.[9] More generally, 44.6% of the affected population had a psychiatric disorder in their lifetime versus 25.1% in those without a family member loss. Presumably, ongoing socioeconomic hardship and suffering caused by the destruction of families continue to reverberate through the population, manifesting in a tendency to self-medicate with drugs and alcohol—anesthetics available to the masses.

Patient Home Visits

After interviewing patients with the visiting psychiatrists for one week, I stayed in Ayacucho for five more days primarily to accompany the clinic nurses, psychologists and rehabilitation team on visits to patients' homes. While working in the clinic had been a memorable and fruitful learning experience, I found conducting patient home visits particularly compelling. Not only are home visits convenient and free of cost for patients, they also provide a mechanism for the clinic to follow-up on patients who either could not make it to the clinic or had missed their scheduled appointments. Moreover, these visits afford clinicians valuable insight into patients' lives, how and where they spend time and how family dynamics operate—critical information for constructing a feasible, appropriate and effective treatment plan. For instance, each visit I participated in informed me about how remote the patient's home was, whether they lived with extended family and their relative degree of poverty.

Some visits were particularly useful from a clinical standpoint, as we were able to observe how patients were functioning in real life. Upon arriving at the gate of one patient's home, the team and I encountered his mother who was hesitant in allowing us to meet with the patient. After waiting several minutes outside, we were finally invited inside and spoke with the patient in his garden. It turned out that for several weeks he had been too paranoid to work at the family bakery and was even reluctant to leave his house. We were able to arrange for him to see a psychiatrist much sooner than he would have otherwise. Another patient we visited with chronic schizophrenia was maintaining a job in construction but reported experiencing increased bothersome auditory hallucinations. Upon further questioning, we discovered that he was taking far less antipsychotic medication than his prescribed dosage due to confusion brought about by having two formulations of the same medication.

After participating in these home visits for a couple of days, I was convinced that they were an essential part of COSMA's model of providing quality mental health care to the rural poor of Ayacucho. Similar to how the use of community health workers has proven essential to HIV and tuberculosis treatment programs in developing countries,[10] the therapeutic importance of incorporating community outreach into mental health services in remote, low-resource settings seems clear. This strategy not only builds strong rapport with the patient and patient's family, but also helps mitigate contextual or cultural misunderstandings between the psychiatrists from Lima and their rural campesino patients. By bridging the gap between the clinic and patients' everyday realities, conducting home visits engenders a more holistic understanding of patients, which in turn facilitates the tailoring of treatment plans to individual life circumstances. This ability, in addition to enhanced monitoring of medication adherence and gathering of collateral information from family members, should presumably result in better outcomes.

More broadly, community-based models of mental health care represent vehicles for providing evidence-based therapies to patients despite severe shortages in human resources. They also hold the potential of affecting change at the level of families and communities as well as making care more culturally sensitive and participatory in nature.[11] In so doing, community-based care may also be a tool for improving public mental health if programs can successfully incorporate "interventions that encompass the social, economic, political, biological and cultural determinants of mental illness."[12] Discovering and implementing strategies to fully realize the range of potential benefits described above in a variety of contexts is a critical challenge facing the rising cadre of global mental health researchers, practitioners and project sites, such as COSMA.

Hospital Nacional Cayetano Heredia, Lima

Just a day and a half after leaving Ayacucho, I began a two-week rotation with Cayetano Heredia general hospital's psychiatry department in Lima. Cayetano Heredia is an academic hospital affiliated with the University Peruana Cayetano Heredia (UPCH) School of Medicine. My rotation entailed working with the consult liaison team during the mornings and with the general outpatient psychiatrists in the afternoons, with a few half days of pediatric psychiatry interspersed.

The first week at Cayetano provided me with an introduction to the psychiatric services offered at the hospital. I was able to observe four different psychiatrists in the outpatient consultorios and see a wide variety of patients and parts of the hospital with the consult liaison service. Throughout this week, I was struck by the diversity of people, pathology and emotion one can encounter walking around a public hospital, like Cayetano, in the developing world. In the emergency room, the distal half of a man's left foot was dangling by some skin and soft tissue after a traumatic accident, while next door rows of patients with various ailments were in different stages of treatment or decline. In the tropical disease unit, room after room of patients with HIV—most not on antiretroviral treatment and many co-infected with tuberculosis or multi-drug-resistant tuberculosis—were in various stages of wasting away. Walking into the outpatient wing, I passed through two rows of happy, talkative, pregnant or postpartum breastfeeding women; this area then opened into an extremely large central waiting room teeming with people patiently awaiting their turn in one of the many booth-like consult rooms that fill the ground floor of the hospital.

During my two weeks at Cayetano, I finished seeing patients with the consult service by lunchtime, thereby leaving my afternoons open to see patients with the attending psychiatrists and UPCH medical students in the bustling outpatient consultorios. This busy, if not over-burdened, service sees both new and follow-up patients for pharmacologic treatment and psychotherapy at intervals determined partly by patient need and largely by clinician availability. Like at

the asilo de ancianos in Ayacucho, I was struck by the way the psychiatrists strived to meet the needs of their patients under less than ideal circumstances. The psychiatry consultorio at Cayetano is an awkward, small construction in the middle of the ground floor hospital hallway, subdivided into three cramped consult rooms. These consult rooms were hot and noisy; there were fans whirling at full speed, and ambient noise entered unimpeded through the rooms' ventilation cracks in the walls. For me, this noise exacerbated the language barrier that I was constantly struggling to overcome, and I imagined that for both patients and providers, these rooms were not ideal "therapeutic environments." That said, the psychiatrists seemed to have developed excellent rapport with the majority of patients, most of whom seemed to genuinely appreciate the care they were receiving.

One other disturbance I experienced in the consultorios was the strong presence of pharmaceutical representatives. In between patients, they often entered the room one after another giving free samples of their branded medications to the doctors. While certainly these free samples benefit a number of patients in the short term, I suspected that, like in North America, this practice would skew physician prescribing practices and unnecessarily promote brand name medications,[13] thereby inflating drug prices.[14] Moreover, the representatives' presence—evidence of pharmaceutical companies' desire to increase sales in emerging markets like Peru—reminded me of how the rise of psychopharmacologic treatment has reshaped how people conceive of and cope with everyday suffering in other parts of the world, such as Japan.[15] I wondered if a similar process was underway in Peru.

Jordan Sloshower

Contributing to this suspicion was my observation that the psychiatrists at Cayetano generally practice a Western style of psychiatry similar to what I have seen in New Haven, in which patient visits are focused on asking questions pertaining to specific diagnostic criteria and assessing patients' treatment regimes. Although used loosely to guide treatment decisions, diagnoses were made according to the two widely used disease classification systems developed in Western contexts—the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD). Amidst a broader debate regarding the universality of mental illness, the use of these classification systems in non-Western settings has led to grave concerns about their diagnostic validity.

Similarities in treatment patterns also seemed to exist despite UPCH's theoretical espousal of a more psychopathological approach based on the work of Cayetano's own Honorio Delgado, after whom the neighboring national mental health institute is named. While this emphasis on psychopathology was certainly evident during weekly academic case discussions, most of the patient visits I observed were "med checks" that entailed briefly inquiring about the patient's condition and well-being and then adjusting their treatment regimen. Like in the US, psychopharmacological agents were prescribed liberally, especially antipsychotics and benzodiazepines, and psychotherapy seemed to play a minimal role in treatment. Unfortunately, it seemed that referral to outside psychologists, social workers or rehabilitation services was beyond the means of most patients.

Given my level of training, I suspect a fair amount of analytic complexity was occurring in the minds of the psychiatrists that I was unaware of. In Ayacucho, one of the Lima psychiatrists had explained to me how the psychiatric interview is like a spiral that twists around itself, as opposed to the more linear, deductive type of interview used in other fields of medicine. In other words, a good psychiatrist generally does not move chronologically through the various parts of a patient's history but rather combines elements from different sections in relevant ways, creating a holistic picture of the patient's life situation. For instance, symptoms described as part of the "history of present illness" must be contextualized within a patient's past medical or psychiatric history and social history. Moreover, allowing patients to tell their illness narratives, which are generally nonlinear, and asking pertinent questions along the way is a difficult but crucial skill for a psychiatrist to master. Nonetheless, it is necessary for understanding how people view their illness and developing good rapport, while simultaneously obtaining the necessary information for a complete psychiatric evaluation. These points would become increasingly clear as I observed more in-depth interviews in the inpatient wards of the national mental health institute.

Instituto Nacional de Salud Mental Honorio Delgado – Hideyo Noguchi

My final two weeks in Lima were spent at the Instituto Nacional de Salud Mental Honorio Delgado—Hideyo Noguchi (commonly called "Noguchi") working in hospitalización (the inpatient ward) and addiciónes (addictions). At Noguchi, the inpatient ward is split into men and women's units, which are further subdivided into acute and chronic wings. Patients first enter the acute wing, and if they are not discharged within approximately three weeks, they are transferred to the chronic wing, where they can potentially stay for years. The majority of patients in the ward carry a diagnosis of chronic schizophrenia, but there are also a number of patients, mainly female, with major depressive disorder, bipolar disorder or borderline personality disorder. Because of the higher diversity of pathology amongst the female patients, I spent most of the first week in the women's unit.

Each morning, I observed psychiatrists in different wings interview patients and then discussed the evaluations with them. I generally focused my efforts toward understanding a patient's diagnosis and the rationale for their medication regimen. There were a few select patients that I found particularly intriguing, so I took the initiative to review their charts and chat with them informally in the common area. This actually proved to be one of the most rewarding experiences of the whole elective, as I felt I achieved a deeper understanding of these cases and formed therapeutic relationships with these patients. The slower pace of inpatient care allowed me to perform follow-up interviews and have more in-depth conversations with the attending psychiatrist about their cases.

One patient that captivated my attention was a young woman diagnosed with chronic paranoid schizophrenia and possible schizoaffective disorder, bipolar type. During my interactions with her, she enthusiastically described to me how she had ended up in the hospital and recounted recent supernatural experiences. She told me about energies she felt from television screens and fears she had, as well as some messages she had intuitively received from a variety of sources. She also elaborated on her passion for learning and career ambitions. What intrigued me about this patient was that she struck me as being exceptionally "normal;" she did not appear disheveled or have the distant, medicated look of many schizophrenic patients I had encountered. Moreover, she was interesting to talk to, and the

things she said were not overtly "crazy" or implausible. Perhaps, if we had been in Ayacucho or a cultural context where speaking of spirits and witchcraft was more commonplace, such remarks would not have evoked suspicion of psychosis. While in Lima, her accounts of the supernatural struck the local psychiatrist as fairly bizarre; they did not constitute the basis of her diagnosis. Rather, it was persistent instances of delusional, illogical thinking exhibited by the patient during lengthy discussions and nuanced questioning that justified her diagnosis. For me, this case exemplified the idea of schizophrenia existing on a spectrum of severity and the need to avoid ethnocentrically applying diagnostic labels on superficial bases that could be explained by differences in worldview. The subtle nature of the patient's psychotic symptoms also underscored the reality that most people with schizophrenia live their lives in the community without treatment.

To provide a contrasting experience to the inpatient wards, I spent most of my afternoons while at Noguchi working in the psychiatric emergency department, which afforded me the opportunity to observe more acute presentations of mental illness. One gentleman, clearly in the throws of a manic episode, dramatized his arrival at the hospital by claiming to be God and shouting, "Heil Hitler!" A young female patient brought in by her mother was relapsing with catatonic schizophrenia after a month-long period of improvement following electroconvulsive therapy. Another striking case was that of an unidentified Quechua-speaking man who had been found disheveled and confused in the street. Nothing was known about the patient's history, and he was given a preliminary diagnosis of paranoid schizophrenia.

While in the emergency department, I also saw a number of seemingly routine follow-up consults, which initially struck me as strange. It turned out that a number of patients without regular psychiatric care have no other option but to visit the emergency department when they run out of medication or have worsening symptoms. This widening crack in Lima's mental health system reflects the lack of space for new patients in Cayetano's public outpatient clinic, Noguchi's reluctance to see outpatients as it strives to become primarily a research institution and the largely unaffordable cost of private psychiatric services in Lima. Despite the demand for outpatient services, there were paradoxically numerous empty inpatient beds at Noguchi, one of only three mental health hospitals in a city of eight million people. One of the psychiatrists I worked with there reasoned that this phenomenon was due in large part to patient preference to seek help at the general hospital instead of the instituto de salud mental, which is not a "normal" thing to do. Thus, although not immediately apparent, a culture of stigma still appears to surround mental health in Lima, as it does in most parts of the world.[16,17]

Patients without regular psychiatric care have no other option but to present to the emergency department when they run out of medication or have worsening symptoms.

Overall, the clinical diversity and depth of patient interaction I was afforded during this first week at Noguchi made for an extremely rewarding experience. In my view, the inpatient setting allowed for better treatment planning, more teaching time and a greater ability to develop relationships with and understanding of patients compared to Cayetano's outpatient service. In fact, having observed similar trends in psychiatric and medical clinics and hospitals in Connecticut has led me to develop a personal preference for hospital-based medicine over outpatient care.

The Addictions Unit at Noguchi

My final week of the elective was spent rotating on the addictions floor at Noguchi. This unit consists of about 25 beds (20 men, two women and three adolescents) and employs an extremely interesting model of care. It was designed and implemented by one of the unit's own psychiatrists and can be described as a holistic, family-centered approach to addictions treatment. This model envisions addiction as a family disease and patients as spiritual beings in need of humanistic development. While interned, patients engage in a full-day program of humanistic or secular spiritual development, which involves writing a "thesis" that outlines in great detail (sometimes in hundreds of pages) the aspects of their lives that have contributed to the development of their current situation and addiction. The program also requires patients to partake in a range of other therapeutic modalities, such as art therapy, daily journaling and reading a curriculum of "humanistic" books. Aside from listening to calming music while engaging in some of these activities and watching a biweekly film, an atmosphere of silence is maintained in order to foster introspection. Moreover, patients are prohibited from conversing amongst one another, except during supervised sessions with one of the psychiatrists.

The program's creator explained to me that the aim is to increase patients' insight into their illness because, according to his theory, all types of addicts (drug addicts, gambling addicts and "cyber" or internet addicts) are not aware of their disease and lack the ability to self-reflect, feel emotions and empathize with others. As a result, they live almost exclusively in the external world, seeking to satisfy their addictive impulses. The resulting tendency to manipulate others in order to satisfy the addiction almost always strongly affects the patient's family. Moreover, a patient's family situation is theorized to potentially contribute to the generation and maintenance of the addiction.

The ramification of this familial association is that the patient's family also must undergo therapy. Initially, patients' families come to the hospital for half-day sessions with the nurses and doctors to learn about addictions and engage in a range of therapeutic modules themselves, such as hugging therapy, meditation and humor therapy. These all aim to increase the family's ability to love and understand the situation of the patient. After an indefinite amount of time, once the patient has made sufficient progress and gained some insight into their disease, the families are gradually allowed increased contact with the patient. The large degree to which a patient's family is considered during evaluation and included in therapy differs from the more individualistic mode of Western thinking but is in line with the cultural value of familismo, "the strong emphasis Hispanic individuals place on the importance of the family as the center of one's experience."[18]

Overall, I found certain aspects of this model quite inspiring and others somewhat problematic. Perhaps the most inspirational facet is the emphasis on therapy rather than medication and the link made between psychotherapy and spiritual development. There is a fundamental respect for each human life that underlies the humanistic program of activities, which seeks to strengthen the individual's mind and spirit to the point where they can free themselves from being enslaved by their addiction. Through this form of self-empowerment, the doctors claim to be able to "cure" patients of their addictions, rather than merely help them maintain abstinence. In theory, the multifaceted, lengthy therapy results in a rewiring of the brain in a manner that defuses the circuits responsible for the patient's addiction.

The most controversial aspect of this treatment model is its extreme length and intensity; the program ideally lasts several years, but patients can only remain hospitalized at Noguchi for a couple months at a time. According to the program's creator, most patients are unable to comply with the demands of the program after discharge from the hospital and, upon relapsing, patients must restart the program from the beginning, including rewriting their thesis. On one hand, the long duration of therapy employed in this model acknowledges the severity and insidiousness of addictions; it is an afflic-

tion that involves all aspects of a patient's life and therefore is unlikely to be treated in a short amount of time. In fact, several long-term patients I met at the head psychiatrist's private clinic where patients live, often for years at a time, stated that it took them about a year to accept the reality of their illness and truly begin to engage the treatment program. Up until that point, they admitted to being fixated on getting out of treatment and resuming their addictive behavior. Fascinatingly, I was able to witness the highly emotional family reunion of a patient who had recently made such a breakthrough after over a year of being interned at the facility.

While certainly such an intense treatment program benefits some patients, especially those with more severe, long-term addictions, it is problematic in that it is employed as a one-size-fits-all program. All patients admitted to the ward engage in the full program regardless of their age, type of addiction, personality or personal preferences. In other words, there is very little tailoring of treatment to the individual patient and little utilization of other treatment modalities, such as cognitive-behavioral therapy or motivational interviewing, which are more commonly used in the United States. Several residents and other psychiatrists also viewed the treatment program as overbearing and unnecessarily strong-handed. One can even make the argument that it is akin to a form of imprisonment, considering that patients' families can legally admit them for treatment against their will.[19] While this infringement of patient liberty could be justified through the lens of familismo as the prioritization of the collective good over individual needs, the head Noguchi addictions psychiatrist emphasized his notion that patients with addictions are not aware of their disease and are enslaved by the addiction, thereby robbing them of the ability to meaningfully exert agency.

Even considering the objections stated above, I still believe this model of care makes a useful contribution to the field of addiction therapy and in some ways instills a much needed dose of humanism into the "med-check" model of modern biological psychiatry. However, the program would be more effective and widely applicable if the hospital and head psychiatrist were more flexible in customizing the program to the needs and characteristics of individual patients and incorporating aspects of other therapeutic modalities.

Final Reflections and Future Directions in Global Mental Health

Over the course of my six-week psychiatry elective in Peru, I was exposed to a wide variety of mental health care settings and providers, types of patients, styles of psychiatric interviewing and treatment regimens. Rather than focusing on learning the nuts and bolts of the field of psychiatry, the rotation afforded a broad exposure to mental health services in the Peruvian context, thereby providing increased familiarity with models of mental health care and new examples with which I could engage the problems of global mental health.

At the outset of the elective, I had been interested in seeing how cultural differences affect mental health care. Specifically, I was curious whether mental illness manifests itself differently in foreign settings and how the Western system of psychiatric diagnosis is appropriately or inappropriately utilized in settings that differ socially, culturally, politically and economically. From studying medical anthropology, I was aware that "different societies and communities have differing norms, values and traditions, a range of causal attributions and understandings and…different ways of expressing emotions, distress and suffering."[8] As a result, the expression of symptoms is rooted in culture and social context, leading to the more accurate term "local idioms of distress."[20]

This is highly relevant in Ayacucho, where qualitative research has elucidated such idioms[21] and found that there are "no equivalent words to 'trauma' and 'stress' among the Quechua-speaking peoples in the Ayacucho highlands."[8] While this does not mean that there are no trauma- or stress-related conditions in this group, it does exemplify the risk of inappropriately applying diagnostic labels that are based on the presence or absence of particular symptoms and behaviors grounded in Western epistemologies. Moreover, Western psychiatric diagnostic schemes and treatment approaches reflect an individualist context that may be inappropriate for collectivist societies. For example, villagers in Ayacucho generally emphasize the social effects of political violence, such as widowhood and orphanhood, rather than individual symptoms of trauma.[6]

Implementing medical interventions in settings affected by socioeconomic problems, such as extreme poverty and political violence, also carries the additional risk of "medicalizing experience," using ideas about disease and illness to make sense of conditions with social and cultural roots."[22] A large body of social science scholarship has criticized the way in which "trauma" and post-traumatic stress disorder (PTSD) have become pathological entities found inside a person, or "between the ears," and a main focus of humanitarian interventions.[23,22,8,6,24,25] This literature has used ethnography to demonstrate how psychiatric services, knowledge and resources can be severely inadequate to address problems rooted in social suffering and can even undermine local healing practices and resilience-promoting processes.

It is with these concerns in mind that I entered the clinic in Ayacucho. Initially, I was somewhat surprised to find that the style of the Lima psychiatrists appeared to be very similar to that of American practitioners—deductively eliciting symptoms, applying diagnostic categories and treating. While in theory, this situation placed COSMA at risk of committing many of the pitfalls discussed above, in practice I felt the clinic's model contained several mechanisms to mitigate this risk. First, the presence of family members at almost all patient visits and the high demand for our services made it clear that patients were visiting the clinic of their own accord, in search of help for very real problems that were not otherwise being addressed adequately. This observation is consistent with ethnographic research from the region in the aftermath of the violence that revealed the community's perceived need and desire for trained psychologists and psychiatrists as well as general psychosocial support.[6] Second, it was difficult to assess whether cultural barriers were specifically impeding the provision of appropriate care. While people in Ayacucho looked and dressed differently, spoke a different language and frequently reported what were considered to be psychosomatic complaints, I did not feel that psychiatrists applied inappropriate diagnostic labels to patients. This was achieved by utilizing DSM diagnostic criteria in a loose, flexible manner—an important and common observation I have found in all psychiatric settings I have been exposed to—and careful contextualization of a patient's problems within their family and community setting. The latter was largely accomplished by including one of the psychiatric nurses or social workers in the psychiatric interviews. Their knowledge of the patients and families from the community and fluency in Quechua helped attenuate cultural differences between the psychiatrists from Lima and their campesino patients.

While I have little doubt that the comprehensive nature of mental health services offered at COSMA represents a promising model for providing community-based mental health care in low resource settings, I do wonder what true excellence in this field would look like. Perhaps the care provided by the clinic could be made more culturally sensitive if psychiatrists learned to evaluate patients' local idioms of distress and employed local illness categories to help differentiate normal from pathological. In addition, efforts could be made to integrate local therapeutic modalities, such as herbal remedies, ritual offerings (pagapu) to the mother Earth (pacchamama), or rituals of restitution (shunqo) and restoration of lost balance into mental health care.[21] Developing guidelines for doing so and evaluating their effectiveness represents an important area for future global mental health research.

In Lima, a more westernized urban center, there are fewer obvious cultural differences and seemingly less risk of "imposing" western psychiatric diagnoses on people from a different culture. Although difficult to comment on as an outsider, one cultural value that did seem to affect patients was machismo. Numerous women invoked this term during clinical interviews while describing emotional disturbances related to relationship problems. The term generally expressed discontent with gender inequalities that were perceived to enable the interpersonal violence or infidelity that led to their psychiatric presentation. The widespread use of such culturally embedded terms, and the knowledge that people living in Lima hail from all corners of Peru and beyond, argue for paying closer attention to idioms of distress and sociocultural factors affecting patients' presentations in urban mental health centers as well those in rural areas.

While cultural factors clearly provide challenges to the provision of appropriate and effective mental health care, I would argue that socioeconomic, political and historical forces are even more salient determinants of Peru's mental health problems and care. This was reflected in the mental health epidemiology in Ayacucho, the dearth of mental health programs throughout rural Peru and the inaccessibility of psychiatric care for many in Lima. As a result, it is critical to embed culturally appropriate, evidence-based clinical care within broader efforts to improve public mental health by addressing the social, political and economic drivers of mental illness in these contexts.

There are some promising signs that this is taking place. For instance, as the social and economic impacts of the massive burden of mental illness become better elucidated, international health and humanitarian organizations are beginning to adopt "resilience" informed approaches to intervention, which prioritize local understandings of illness and wellbeing and seek to promote dignity rather than merely avoid pathology.[26] In addition, by analyzing multiple levels of influence ranging from the structural through the community to the individual and building upon existing health-promoting resources, structures and processes throughout the "social ecology," such efforts hold the potential to both increase cultural specificity and promote social justice.[26,27]

Overall, my exposure to the mental health care system in Peru has expanded my vision of what mental health care is and what it can be. The field of psychiatry is, for better or worse, still in its formative stages; it is in the process of revamping its diagnostic classification systems and discovering the biological and social bases of mental illnesses. As these changes take place, so too will models of mental health care. Despite these limitations inherent in modern psychiatry, there is an epidemiological and ethical imperative to expand access to basic community mental health services that provide evidence-based therapies for a range of common mental illnesses. Fortunately, the field of global mental health is growing to meet this need. However, as it does so, it is critical that its practitioners develop and implement innovative, interdisciplinary, inter-sectoral approaches to care that are responsive to constructive criticism from the social sciences and local communties. My time in Peru has powerfully inspired me to be part of this monumental effort in the hope of alleviating the individual and collective suffering that results from the vicious, circular relationship between mental illness and unrelenting political violence, poverty and gender inequality that plagues communities around the globe.

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