The Royal College of Psychiatrists is keen to attract high-calibre doctors to the specialty of psychiatry and to foster good attitudes towards psychiatry and the College as a whole. The Psychiatric Trainees Committee and the Board of International Affairs therefore offer bursaries for medical students looking for financial support with their electives in psychiatry or to undertake research in the UK or overseas. Three recipients of these bursaries have contributed correspondence on their experiences.

Psychedelics and psychiatry

Sir: In 2008 I received a bursary from the Royal College of Psychiatrists to contribute towards expenses incurred during my medical elective in the USA, 'Psychedelics and psychiatry'. This letter gives an overview of my experience to date and plans for the remainder of my project.

Psychedelic drugs, medicine and popular culture have a turbulent past. Intense research into hallucinogenic substances followed Albert Hofmann's legendary ingestion of LSD-25 in 1943 (Hofmann, 1980). The potential of psychedelics as psychiatric drugs led to several undergoing diverse trials, ranging from adjuncts to psychotherapy to the treatment of addictions (Abramson, 1967; Passie, 1997). Over 2000 papers documenting the safe use of psychedelics in more than 40 000 patients had been published by the mid-1960s (Sessa, 2005). Although the scientific rigour of some work is questionable by today's standards (Grob, 1994), enough potential was shown to warrant follow-up. This never happened; LSD was adopted by the counter-culture and subsequently blamed for the social unrest of the time (Grob, 1994; Dyck, 2005). By the early 1970s, increasingly strict legislation and lack of government support halted research into psychedelic substances.

Psychedelic medicine is now experiencing a renaissance, however, with several active groups worldwide (Sessa, 2005). I chose to join Dr John Halpern's Laboratory for Integrative Psychiatry, Addictions Division, at McLean Hospital, Harvard, as a research assistant for 2 months. Dr Halpern has over 10 years' experience in the field, McLean is world renowned for psychiatric research, and Harvard has historical links with past psychedelic studies.

The first part of my elective has focused on non-clinical work. I have been actively involved in the construction of a new trial, learning about study design, proposals, applications, protocols, informed consent, legal requirements, institutional review board (IRB) approval and funding issues. The trial is a randomised, placebo-controlled study of psilocybin for the treatment of episodic cluster headache. Psilocybin is the hallucinogenic active ingredient of 'magic mushrooms'. It is an indole of the tryptamine family of compounds.

I will have the chance to discuss the prospect of psychedelic therapy with potential patients, and meet leading European psychedelic researchers as part of this project. This new trial is currently under IRB consideration and their feedback will provide a valuable learning opportunity.

The second part of my elective focuses more on clinical experience. Recruitment is ongoing for another trial, in which patients with refractory anxiety related to a diagnosis of cancer undergo a number of psychotherapy sessions while under the influence of MDMA (or active placebo). MDMA (3,4-methylenedioxymethamphetamine) is a member of the amphetamine class of drugs, and is more commonly known by its street name 'ecstasy'. I will be able to observe psychotherapy under these unique circumstances and learn some of the practicalities of running experimental sessions.

My last task will be designing an online survey for MDMA users with autism-spectrum disorder to help gather data for a series of case reports as groundwork to support future clinical trials.

Finally, I have just learned that work on an unexpected offshoot of my elective project has led to my first academic publication (Halpern *et al*, 2008).

My brief experience of psychedelic research has exposed me to a diverse array of subjects beyond the core medical curriculum, as it touches upon medical, ethical, philosophical, spiritual, social and legal issues. Over 60 years since 'Bicycle Day' (Hofmann, 1980), these fascinating substances still prove controversial. Technology has now made it possible to visualise the brain in action; psychiatric research is on the brink of a revolution. Nevertheless, with a history of shamanistic use dating back millennia (Schultes *et al*, 2001), perhaps current psychedelic research is rediscovering what could arguably be described as the oldest branch of medicine.

Sean Doherty
Year 5 medical student, School of Medicine, Cardiff University, Wales, UK, email dohertys1@cardiff.ac.uk

Abramson, H. A. (ed.) (1967) *The Use of Psychotherapy and Alcoholism*. Bobbs Merrill.

Dyck, E. (2005) Flashback: psychiatric experimentation with LSD in historical perspective. *Canadian Journal of Psychiatry*, **50**, 381–388.

Grob, C. S. (1994) Psychiatric research with hallucinogens: what have we learned? *Yearbook for Ethnomedicine*, **3**, 91–112.

Halpern, A. L., Halpern, J. H. & Doherty, S. B. (2008) 'Enhanced' interrogation of detainees: do psychologists and psychiatrists participate? *Philosophy, Ethics, and Humanities in Medicine*, **3**, 21.

Hofmann, A. (1980) *LSD: My Problem Child*. McGraw-Hill.

Passie, T. (1997) *Psycholytic and Psychedelic Therapy Research: A Complete International Bibliography 1931–1995*. Laurentius.

Schultes, R. E., Hofmann, A. & Rätsch, C. (2001) *Plants of the Gods: Their Sacred, Healing and Hallucinogenic Powers* (2nd edn). Inner Traditions.

Sessa, B. (2005) Can psychedelics have a role in psychiatry once again? *British Journal of Psychiatry*, **186**, 457–458.

The doctor–patient relationship in Australia's Northern Territory

Sir: In the summer of 2007 I spent 6 weeks in the northern Australian city of Darwin. During this period I had the privilege to work in the Royal Darwin Hospital alongside the renal medicine team. While undertaking this placement, I was exposed to the fascinating lives, and plights, of the Aborigine people who heavily populate this region.

During my stay I became intrigued by the differences that I observed in the doctor–patient relationship between Western Australians and this sub-population, in particular, the nuances that were adopted by the medical professionals in their struggle to accommodate Aborigine traditions, beliefs and culture while they were attempting to employ mainstream (biomedical) Western medical concepts. My work focused on observed differences in both verbal and non-verbal methods

https://doi.org/10.1192/S1749367600000497 Published online by Cambridge University Press

of communication, such as the intentional absence of eye contact or expected discussion of a patient's condition with the elder of a community group. These exchanges were particularly revealing, as it became evident that not only verbal communication but also body language is culturally specific and, as such, open to misinterpretation.

Further to this, I engaged in meetings with the hospital's translator services, consultants, nursing staff and patients. Through them I was made aware of the educational tools used to strengthen communication between staff and patients. These included posters, books, leaflets, radio broadcasts and community meetings, all established in an attempt to integrate the healthcare paradigms of the Aborigines with the Western approach to medicine.

Throughout the study it became apparent that the Aborigine people had suffered serious psychological damage from decades of displacement and were finding it difficult to cope in a climate of change and cultural overhaul. For example, the relatively new abundance of alcohol has led to its frequent misuse by this group. This has become such a problem that, on 17 September 2007, the Federal Government of Australia imposed a drinking ban in certain Aborigine districts. Many in, and out, of the region feel that these measures are too quick, easy and generalising, and miss the root of the problem.

There is a specific need within the mental healthcare system to understand the normal behaviour and health patterns for a population, so that professionals can intervene more appropriately. For example, to diagnose a patient as suffering from delusions, a physician is required to have an adequate understanding of what is a normal belief for that patient's culture and society. It is difficult to feel confident in such diagnoses if, at very basic levels, there is inherent miscommunication and misunderstanding.

The challenges in communication between Western medics and Aborigine patients in Australia's Northern Territory affect the mental well-being of this population and in many cases have led to patients absconding from the hospital system. They have resulted in much neglect of health, both physical and mental. Through a lack of efficient communication between the health system and the Aborigine community, and the subsequent frustrations suffered, malnutrition, depression, child abuse, alcoholism and substance misuse are rife in this region.

Although, in Britain, we are fortunate not to have such an obviously displaced sub-population, I am reminded through this work of the continual need to assess cultural differences when recommending healthcare pathways to patients. There is, I believe, evidence that good mental health begins with a feeling of being understood.

Marcus Cumberbatch
University College London Alumni,
Chesterfield Royal Hospital

Correction

Helping each other help children – worldwide research networks in child and adolescent mental health. *International Psychiatry*, **5**, 84–86. The authorship of the paper should have read: 'Stefan Ehrlich, Nicolas Jefferson-Lenskyj and Paul L. Plener'. The second author's affiliation is: '4th-year medical student, University of Queensland, Australia'.

The mental health initiative of the Association for Health and Welfare in Nilgiris

Sir: I spent my medical school elective placement in the foothills of the Nilgiris valley in the southern Indian state of Tamil Nadu. The mental health initiative of ASHWINI (Association for Health and Welfare in Nilgiris) works among the Adivasis 'original inhabitants' of the Gudalur and Pandalur Taluks. I was particularly interested in understanding the indigenous influences on the delivery of mental healthcare. The opportunity to conduct qualitative interviews with community mental health workers and practitioners gave me an insight into native experiences of mental health within a specific environment.

Although there was strong representation of biomedical ideas among the community mental health workers, a biomedical model inadequately represents the complexity of individual concepts of illness. Care was delivered in a combination of mystic models (more akin to community ways of thinking) and biomedical models (representative of allopathic medicine). This combination forms a holistic medium in which patients are cared for with spiritual, physical and social welfare considered. I found ASHWINI's healthcare delivery impressive, arguably affording patients a better prognosis when managed within a community rehabilitation system, than did the frequently fragmented care and social isolation I have witnessed in the UK.

Adivasi culture is very inclusive, with exclusion from society a rarity. It struck me that the minutiae of mental disorders appearing in Western criteria may represent behaviours in Adivasi societies accepted within the spectrum of normality. There is a danger in introducing Western classifications into mental health practice in diverse populations. The distinction between disease and psychiatric disorder has been confused, and the mapping of criteria for pathology onto culturally diverse experiences may be false and clinically useless. Research has highlighted the need to understand common vignettes of mental illness and social pressures acting on society in the creation of effective services. The overwhelming need is not to develop a universal gold-standard model of care, but one that is culturally conducive. The most valuable lessons from this research are the cultural insights offered about Adivasi communities, for example the need for prevention and assessment of suicide risk (suicide has been the most common outcome of those with mental illness) and acknowledgement of the central role of the family unit within the community when diagnosing and managing psychiatric illness.

Ultimately, the greatest priority in mental health is appropriate and accessible services. In order to create effective, community-orientated interventions there is a need for exploration and understanding of community dynamics. I hope that the research I conducted with the aid of the bursary will both provide further perspective on the delivery of effective mental healthcare and contribute to the development of culturally sensitive interventions.

Lauren Hill
Year 5 medical student,
Brighton and Sussex Medical School

https://doi.org/10.1192/S1749367600000497 Published online by Cambridge University Press