Sonya Virani:

Hi, I'm Sonya Virani and I welcome you to Finding Our Voice, Fresh Perspectives in Psychiatry, a podcast series hosted by me. This podcast has been developed with the goal to address current issues as they pertain to psychiatry, with a special focus on including the viewpoints and opinions of younger groups, resident fellow members, and early career psychiatrists. Thank you for joining me as we continue our discussions on this new segment of the podcast series about social determinants of mental health.

Today's episode will focus on the exposure to war, violence and shootings and the impacts of migration. I would like to welcome to the third episode of this segment, Dr. Eric Jarvis from McGill University in Canada, and Dr. Victor Pereira Sanchez, who spends his time between Columbia and New York University in the United States. Dr. G Eric Jarvis is an associate professor of psychiatry at McGill University and Director of the Cultural Consultation Service, the first episode Psychosis Program, and the Culture and Psychosis Working Group at the Jewish General Hospital.

His research interests include the cultural adaptation of psychoeducation for early psychosis, linguistic barriers in mental healthcare and religion and mental health. He's also interested in the academic editing and the history of psychiatry. Welcome to the podcast, Dr. Jarvis. I am so glad that I finally have someone who's so well known in the world of cultural psychiatry and has such a flare for conveying his thoughts and ideas so articulately.

Dr. Jarvis:

Thank you, Sonya. I'm glad to be here.

Sonya Virani:

Thank you Dr. Jarvis, and Dr. Victor Pereira Sanchez is a child, adolescent and adult psychiatrist based in New York. He obtained his medical degree in 2014 at the Universidad de Navarra in Spain, where he also completed a clinical residency program in psychiatry in 2019 and received his PhD in 2021. He conducts research in local and international global mental health projects as a foundation Alicia Kaulitz, postdoctoral research fellow in global mental health and implementation science at the Department of Psychiatry at Columbia University and the division of Translational Epidemiology at the New York State Psychiatric Institute, NYPSI. He teaches child and adolescent mental health and medical ethics as a clinical instructor at the Department of Child and Adolescent Psychiatry of New York University Grossman School of Medicine, and at NYU College of Arts and Sciences. Welcome, Victor. It is so nice to have you on the podcast.

Dr. Pereira Sanchez:

Thanks for having me, Sonya. It's an honor to be a guest in my favorite podcast.

Sonya Virani:

Thank you, Victor. All right, so being forced to flee your home is a life-changing event. Now negative impacts naturally persist long after the conflict has ended. A 2018 article by M. Vaughn, [inaudible 00:03:27] At All in BMC Psychiatry noted that the number of asylum seekers, refugees, and internally displaced people worldwide has increased dramatically over the past five years, and many countries are continuing to resort to detaining asylum seekers and other migrants despite concerns that this might be harmful. This extensive literature review, which I recommend you read if you have some time, illustrates the severe mental health consequences among detainees across a wide range of settings and jurisdictions. And while we might all still be aware of the challenges and tragic impacts that

displacement leaves on individuals, particularly on children, I wanted to start off with something on a less heavier note. Being an immigrant myself, I quite relate to this.

I was watching the trailer of this documentary called A Kandahar Away. It is a little bit of the longing that every immigrant kind of experiences when they're away from their own homes and here, so let me tell you about what it was. So as an immigrant to Canada, Abdul Bari Jamal's longing for his homeland of Afghanistan is a constant theme in his life. This guy is now living in Toronto in Canada and he never thought that he would find a piece of his former home right here in Canada's heartland. So delighted by his discovery, he decided to buy every member of his family a plot of land in the dwindling farming community of Kandahar, Saskatchewan. A Kandahar Away follows the Jamal family, all born in Kandhar in Afghanistan on their first family trip to see the land. Now, while Abdul Bari Jamal is trying desperately to maintain ties with his homeland and with his culture, his children have grown up here in Canada and Canada seems to be home to them. Ultimately however, his children see how much meaning there is in his act of tying his family together to his homeland.

And while Abdul feels this eternal exile and longing for Afghanistan, the Jamal siblings grew up here and Abdul celebrates Canada's military involvement in Afghanistan as a success. But the five siblings oppose the occupation of Afghanistan by the NATO countries. So obviously there are some very conflicting viewpoints within the family and this also illustrates what a lot of migrant families go through from time to time. However, bringing it back to the topic that we actually have at hand, let me turn it over to Dr. Jarvis to take us through a very interesting, yet complex case about a woman called Mara, whom he sees in his outpatient clinic. Off note, the cases that will be discussed today only carry details from the guests' accumulated years of experience, and neither pertains to any specific real life individual. So Dr. Jarvis, over to you.

Dr. Jarvis:

Thanks again, Sonya. So I'd like to share a case that we saw in McGill University in Montreal, Canada at our cultural consultation service. And there we see mostly immigrants and refugees who are referred to us to understand better the cultural context of their psychiatric symptoms and other problems that they're facing. So this particular case is a woman from West Africa and she had been undergoing an asylum claim. She was actually in the court during the hearing and she couldn't proceed very well. The judge and other people noticed that she was not able to communicate and so they were worried about her. So they stopped the hearing and they referred her for an evaluation. And so this is how the cultural consultation became involved, to try to help this woman to advance her case and to help her to be more able to undergo the refugee hearing.

So when she came to see us, in fact she continued to act the same way, in some ways. She was kind of staring blankly, having a hard time responding to questions, but she really was very valiant and brave and continued with the interview. And so we were able to spend maybe two to two and a half hours trying to understand better how to help her and how to understand her problems. So we had an interpreter present, which was very important because this woman didn't speak English. And so the interpreter was of great help and also a great support to the individual, to the patient herself. So what happened essentially was that this woman had fallen into very difficult times in the country of origin a few years ago and some of the members of her community accused her of witchcraft or of sorcery and of causing some harm to come to people in the community, to some members of the community.

And so they essentially decided that they were going to take away her life, they needed to end her life. So they tried to assault her, they did assault her, they did humiliate her. Fortunately she was saved by some friends and taken and put into hiding. And when she was in hiding, after a while her attackers continued to find her, tried to find her. They wanted to kill her as I mentioned, because they were afraid

that she was doing something harmful to their family members. So essentially after hiding for a time, some friends of hers, other friends of hers, found a way for her to leave the country and go directly to Montreal and to Canada where she was attempting to start a new life.

In Canada, it continued to be difficult for her because she was having a hard time retraining, a hard time gaining access to services. She was having a hard time finding work and finding training, finding skills that would help her to get work and also having a difficult time learning English. And in Montreal we have to learn French as well. And so she was having difficulty with all these different problems. So her symptoms were quite severe actually. And for this reason, the severity of her symptoms and the problems that she came out of from her country of origin made it difficult for her to advance her case and advance her life in Canada.

Sonya Virani:

Dr. Jarvis, I must say that the description of this attack on this woman is rather ghastly. It's only something that I ever read about in books and never really thought that could still take place just five years ago. And of course you touched upon the pre-migration and post-migration stressors that Mara experienced. On that note, I do have some questions for you about Mara and her younger years. Would you please be able to give us a picture about how Mara's life had been pre-migration, especially right before the attack in the village and for how long had she really been experiencing the hardship in different forms? I ask this because I'm very curious and it seems like the only real support she had were the few friends that saved her from that attacking mob.

Dr. Jarvis:

Yeah, you're right to highlight the pre-migration stressors. So usually when we're evaluating refugees and immigrants, we're looking for pre-migration, migration and post-migration stressors and problems and you are right to have a hunch that this particular individual was in a disadvantaged position before she ever even came to Canada. So we often think of migrants having a lot of troubles coming to the United States or Canada, other places and encountering a lot of difficulties there.

But in fact, a lot of people have had a lot of difficulty their whole lives. And that was the case with this woman. She came from a disadvantaged position, a position of poverty, of no education, and her parents, she didn't have parents in her life during her early years. And so this launched her off into a very difficult beginning. And then eventually, I think because of these disadvantages, she was singled out by people in her community as somebody who may in their minds cause trouble or maybe somebody to turn to if they were angry or upset, they could maybe attack her without much consequence.

Sonya Virani:

Now obviously we're trying to protect the confidentiality of this case and of this individual as far best as we can. How about her life in the post-migration period? She must have gone through this whole process of asylum seeking and all the hoops that immigrants have to usually climb through while relocating to another country, right?

Dr. Jarvis:

Yeah, absolutely. So her story is a bit complicated in that she came to Canada and she didn't have a very good representation at the beginning of her refugee claim. And so she was initially refused, but fortunately she's had a successful appeal and is able to go on and have a fresh start. And that's partly why we're involved is, we're trying to help her now to mount a good case and to have proper letters and

proper support in order to have a just outcome this time, which I think would be to be accepted to Canada. I think if she had the proper representation.

She has a lot of symptoms too that are making it difficult. So for example, she has nightmares still. She cries out in her sleep quite a bit. She has a lot of re-experiencing of the trauma that she had in the country of origin, which is really distressing to her. And even during the evaluation she has these re-experiencing episodes, which are hard. You have to be patient and not too rushed to get the information that she can share and she wants to share. It's just that it takes more time than for most people.

I was just going to mention one last point, and that is that this woman has areas of strength as well. She's a very devout religious person and she has a difficult time going out to services in the community, partly because of covid, but also because of these symptoms that she's been having, these terrible all-encompassing symptoms. But nonetheless, she really relies on her religious faith to get her through her problems. She prays often and she fasts as well, which she gains strength from fasting, from praying, from listening to the Bible. She can't read, she has never learned how to read, but she can listen to the Bible and derives a lot of comfort from that. So her main question is she just doesn't understand why she was singled out. She's always been such a devout Christian her whole life. Why was she singled out as somebody that was involved in sorcery or trying to harm other people? This is the question that she's really struggling with.

Sonya Virani:

Right. I'm fairly certain she must be pretty grief stricken by whatever had happened and there must have been lasting impacts that translated themselves into different kinds of symptoms. Now, did she ever feel like she was that distraught or that depressed that she just did not want to live anymore? Did suicide ever come up in conversation?

Dr. Jarvis:

It has with her, yeah in the past. After she came to Canada, it was a very dark period for her getting used to life in Canada, such a different country than what she's used to. Having little or no support really was hard for her. And she did entertain suicidal thinking for a while and went on treatment briefly for that. But these days she's feeling more supported and I think she has a better chance at a good future. But she says that if she were forced to go back to her country of origin where she's quite sure she would be killed, she's not sure that she would be able to do that. So she would prefer dying than to go, than to be returned forcibly.

Sonya Virani:

So less seasoned clinicians might often find that an odd manner of presentation, which might include blankly staring into space, et cetera, would just be interpreted differently, right? Some form of psychosis, possibly a dissociative phenomena. What do you have to say about that?

Dr. Jarvis:

Yeah, for sure. Dissociation, I think can be misdiagnosed as psychosis. I think that it can be, a lot of people might wonder about or suspect psychosis and a person with this kind of presentation, but for me, she quite clearly fits more of the criteria for a dissociation, dissociative episodes. Dissociation, I'm sure that many of the listeners know is a confusion in which people lose track of time and place. It's due to anxiety and in this case it's due to traumatic, post-traumatic anxiety. So for this patient, there are moments where she kind of almost returns to a previous time while she's during the interview and starts to feel like the events are happening again around her. And she might hear sounds, she might

hear voices, and so on that are connected to the trauma. It's not the typical voices or noises or auditory hallucinations of say, schizophrenia, which are more bizarre and unusual and persistent and unrelated to, not necessarily at least related to past trauma.

Sonya Virani:

You do make a very interesting and important point because it seems like this is an important clinical pointer to convey to various providers and clinicians who might misdiagnose this kind of presentation as even PTSD, something dissociated disorder related, et cetera. So any last thoughts about messages you'd like to convey to audiences doing clinical work to treat such patients?

Dr. Jarvis:

There are some things that people can really put into play that will make a big difference I think. The first one is that people ought to give a little more time to complex patients who are coming from diverse backgrounds, maybe immigrants, especially refugees who need an interpreter. Don't try to put these patients at the small parts of your clinical schedule, reserve enough time to meet with them and for sure have an interpreter present if you're in doubt of the person's ability to communicate. People may speak a little bit of English or enough English to get by day-to-day, but in reality when you're talking to them about important matters, about sensitive emotional topics, your conversation may quickly surpass their ability to talk to you meaningfully. And also for them, many people are so appreciative if a professional interpreter is present, of course with their permission, if the interpreter is present, they can maybe for the first time really express what's happened to them in a non-judgmental setting.

It's also important I think if you're working with a refugee to speak directly to the client or the patient's lawyer, be an advocate for them. You have power as a clinician, you have power as a psychiatrist and you can speak to the lawyer and you can ask the lawyer, Well, what kind of a letter could I write that may be helpful to this person if there are legitimate concerns and mitigating factors. If you kind of go through these different steps and you can sometimes listen to the interpreter and you can hear what the interpreter may have to say about the client, that's a very good source of information. An interpreter can sometimes give you a lot of culturally attuned information about your client.

But if you still may need more help, don't be ashamed. If you're not sure what's going on now, you can get help. You can talk to the interpreter, to family members if they exist. In our case, we didn't have family members available. You can also go to what we call a culture broker, which is somebody from the community of origin of the person who can act as a bridge between the culture of the patient and the culture of medicine and psychiatry. And we do use culture brokers in our work at the Cultural Consultation Service in Montreal.

Sonya Virani:

Wow, this is amazing. Canada really seems to be many steps ahead. Thank you for these words of wisdom, Dr. Jarvis. It definitely seems like a reminder that we as psychiatrists certainly are uniquely positioned to wear many different hats in our roles that we play in patients' lives. As not only as treating clinicians, but also as advocates, as people who can convey different kinds of education to various stakeholders involved in the process. So I really appreciate the summary and the clinical pointers you just provided to us. So with that, let me now switch gears a little bit and take you all to the next case that Victor will discuss with us today. Victor.

Dr. Pereira Sanchez:

It's about Hayad. So she is 33 year old Somali American. She's a Muslim and she's a law student in Minneapolis, where there is a huge community of Somali refugees and Somali in the [inaudible 00:21:17]. So Hayad was born in Borama, Somaliland. Somaliland is a sovereign state in the Horn of Africa, is internationally unrecognized as a sovereign state, rather it's recognized as a region of Somalia. So Hayad came with her parents when she was a child after they fled civil war in the nineties. And in particular there was a massacre that took place in their hometown in Borama in early 1991. So she was a toddler at the time and there was one day they were at home, she was with her parents and extended family and [inaudible 00:21:58] broke into the house and shot at everyone, killing her 12 year old cousin and her aunt and wounding her mother. Also the munition man killed many other people including friends in the town.

So in such dangerous circumstances they left Somalia, but for a year and they end up in Minneapolis. So decades later, when she was already in her thirties, she went for an appointment at the office of her primary care provider and amidst conversations, her PCP discovered that she had been engaging in excessive hand washing and repetition of Muslim daily prayers. So this had started about two years ago. So she used to wash herself for the prayer, which typically includes washing hands, face, arms, legs, and cleaning ears and her. So normally this would take two minutes in the house or in the most, and it's a normal routine ritual for Muslim prayers. However, she would do this, since she started with these symptoms that the PCP was trying to understand, she would do this repetitively for 30 minutes, even some days up to an hour. And she was claiming that, quote on quote, is passed via her anus.

So her washing rituals would get constantly broken and must be repeated. So the PCP further inquired and she had yet revealed that she was repeating the ritual in the house. She was taking more time in the toilet than their family members. And this was creating a problem because other family members could not use the bathroom and they would get late to the prayers. And it's not like that she's completely oblivious of how much distress and interference this was causing her. In fact, she felt so disturbed and ashamed that she stopped going to law school. And of note, she not have psychotic symptoms, she didn't feel depressed. And even knowing her history and her trauma, she didn't even endorse symptoms or classical symptoms of PTSD.

Sonya Virani:

I see. Victor, that's very interesting. Let me just pause you here because if I understand this correctly, there is a woman who experienced a shooting and killing of certain family members and then she went over to Minneapolis and then decades later she developed these excessive hand washing symptoms and was completely distressed by it and it had some very serious consequences on her life. Now, one thing that might be coming up in the minds of our listeners and perhaps you both as well, how does one connect to the emergence of these compulsive symptoms, should I call them of excessive hand washing, et cetera, more recently occurring with the experience of hardship and trauma from several years ago, like the shootings that you alluded to. I'm thinking that this hand washing behavior is clearly a compulsion which goes over and beyond an exaggeration of the religious practice in Islam to wash your hands in exposed areas prior to prayers. Are you aware Dr. Jarvis about how these kinds of symptoms could possibly be connected to trauma?

Dr. Jarvis:

Yeah, I think it's just important to remember that reactions to trauma are diverse and varied. So I mean there's so many ways people can express their distress. And I think in this particular case it's likely that there's a connection as you're saying. I mean there may even be a post-traumatic subtype of OCD and as with a major depressive disorder, OCD may coexist with post-traumatic stress disorder. So you often see

major depressive disorder with PTSD pictures. And maybe there's an, I think we should expand a little bit and think about OCD being a possible comorbid problem.

So people may have a predisposition to OCD and if they encounter severe trauma as in the case of this person, it may just exacerbate the underlying predisposition to OCD. It may complicate treatment, it may make it a treatment resistant case. I don't know, maybe we'll discuss treatment soon for this person. So I guess the bottom line in my view would be if we're assessing people with clear OCD, don't forget to ask about trauma. And if we're assessing people with clear PTSD, don't forget to ask about OCD-like symptoms because there's going to be quite a bit of overlap I think.

Sonya Virani:

Right, right. And while researching this aspect myself, purely out of curiosity sometime ago, I came upon this article which says, which is titled actually the Impacts of Stressful Life Events and Traumatic Experiences on the Onset of Obsessive Compulsive Disorder. It was published in the Frontiers of Psychiatry in December of 2020, just last year. And the study comes out of the Department of Neuropsychiatry at the Kyushu University in Fukuoka in Japan. And it is by Muramaya et al. It's a pretty big study because they investigated 281 patients with OCD and compared the clinical characteristics among groups with or without stressful life events, including traumatic experiences.

As a result, 172 of those, which is 61% of the participants had experienced various stressful life events, but 34% of them had traumatic experiences before the onset. So the participants who had stressful life events showed more contamination and fear symptoms compared to those without such life events and patients who had specific traumatic experiences showed a tendency toward hoarding obsessions. So it might be worthwhile looking into these things as we clinically try to manage the patients who might come up with varying presentations of symptoms, even OCD, which might very well be connected to trauma in the past. Victor, would you please go on and tell us more about what happened with Hayad's case?

Dr. Pereira Sanchez:

Of course. So Hayad refused to acknowledge these behaviors, that these behaviors could be due to mental health disorders. Actually her family refused as well to understand these symptoms as a potential mental health disorder. So the patient declined to be referred to mental health assessment and instead the family took her back to Somaliland to her hometown in Borama and they saw a sheik that is the name they use for the Imams that are the leaders in the mosques in Somalia. And this Imam assess her and he understood that the family was attributing the symptoms of the patient to [inaudible 00:29:16], a spirit in Islam. And this spirit was not wanting Hayad to pray. So however, the Imam in Somali land who saw her was trained in mental health literacy. Actually he was among a group of religious leaders who attended a community mental health awareness training in Borama. And that was delivered by a friend of mine, Dr. [inaudible 00:29:46].

And so this Imam, he call a physician here and he called Dr Handay and together they connect this patient with actually with a mental health provider in the United States that was very knowledgeable and expert in treating Somali refugees. And eventually the patient accepted to that treatment because it was recommended by the Imam in Borama. So she was diagnosed with OCD and she was put with SSRI and with cognitive behavioral therapy. And the response actually was excellent after a couple of months and also doing the work with the therapist. So Hayad admitted chronic moderate somatic symptoms. So headache, stomach aches actually between college that she have studied liberal arts and law school. There was a gap of some years and she disclosed that she had that gap because these somatic symptoms were very impairing to her and she was very ashamed to present in public because of them

and all these symptoms of psychosomatic nature, as assessed by the therapies and apparently related to her childhood trauma. And those were incorporated to therapy and also improve with time.

Sonya Virani:

Right. Thank you Victor. It is very, very interesting to me to note the role that this Imam had played in the life of this individual. He really seems to have played a pivotal role basically. And I think that he is more of an exception to the rule. This man seems to have had some mental health literacy himself and just because he was basically a member of their own community, I think he played more of a mediator sort of role to connect her to the correct services that might have been beneficial to her, which I will visit in just some time. But for now Victor, what clinical pointers would you have from this case for our listeners?

Dr. Pereira Sanchez:

Well all cases and all the practice of medicine, at least in my view and the view of many people should be understood within the biopsychosocial model. And this is a great case. So if we will treat this patient by the books, well first of all she would not go to mental health treatment in the first place. So it was great that this patient have the opportunity to discuss these symptoms with a person, in this case Imam that was also knowledgeable about mental health and also that eventually she was connected to psychiatrists and to therapists that had this cultural humility and this cultural understanding of the issues that these particular community, in this case that so many refugees faced. And there are a lot of social cultural issues to take into account in general in communities like things. And for that, some guidelines can help the codes of the DSM, also the cultural information interview of the PSM.

But some issues to take into account is the trauma. So we have to screen for trauma and account for trauma in most cases. Sometimes trauma can come through violence. In this case there was an exposure to a very violent episode, but sometimes the trauma can be cumulative and also there's a lot of stress, episodic stress, but also a lot of chronic stress. And this stress can be accumulated through the migration. Sometimes refugees, they don't just come to the United States or to Canada, they have a route that has a lot of steps and in different steps they can suffer a lot of hardship.

And also we have to take into account the culture where they come from. They may have a different idioms for mental health distress and they may have a different understanding with a different level of stigma towards mental disorders. And of course the role of religion here took a big place and it's something to take into account. But also a very interesting clinical pointer is that even when we look at refugees and even if they come from the same country, we have to understand that each case, each person is very different. For instance, even if Somaliland is not a big region and there are different clients, so it is possible that different clients are expressing mental health distress or are having different understanding of the symptoms or different acceptability to assessment to interventions. So it's very important to individualize every case.

Sonya Virani:

Thank you Victor. And I just wanted to draw your attention to two very important resource documents, which I think might be useful. One is the supplementary module to the core cultural formulation interview, a specific section which is dedicated just to immigrants and refugees, which Victor briefly alluded to and has some very specific questions to be asked in the following subcategories. Background information, where people inquire of the country of origin, how long they've been living here in the host country and in the country of origin, and why did they leave, pre-migration difficulties prior to arriving and then obviously some subjective information about hardship, persecution, or even violence

perpetuated against them or their families, migration related losses and challenges, especially for persons who were important or close to them or those even who stayed behind. Other people leaving a country often experienced losses and those losses don't have to just be in the form of death, but obviously separation is just as traumatic for a lot of people.

Geographic separation, things about challenges related to the journey, whether or not the family misses anything about their own way of life from their country of origin. And then an ongoing relationship with the country of origin, resettlement and a new life, a relationship with the problem at hand, the primary problem at hand and what their future expectations would look like for them and their family.

And I also came across a comprehensive document, which is by the UNHCR or which is actually the United Nations High Commissioner for Refugees. This one is titled Culture Context and Mental Health of Somali Refugees. And it gives an extensive guideline for things to be kept in mind, especially as it relates to the Somali population, in case anybody is interested in going over it. Finally, as we come to the end of this, I wanted to just take us back to that thing about the Imam playing a very pivotal role in this lady's case. So here it brings to my mind the idea about trust that Hayad and her family and many others like her are likely to place in leaders of the community, whether they're religious like the Imam here or otherwise. Now what do you think of this Dr. Jarvis?

Dr. Jarvis:

Oh, thank you. This is another really good point to raise. I'm glad that Victor wove this into the case that he talked to us about. Because I think that working with religious leaders and religious communities, especially when we're dealing or working with people from minority backgrounds or maybe people from immigrant or refugee backgrounds, is that this is a very neglected part of our work. We have to remember, I mean in Canada and Quebec especially where I'm from, we come from very secular societies. So a lot of people are not religious. In other places, the majority of people are intensely religious. So religion and spirituality plays a very important role in their lives. Even if they themselves are a little bit on the margins, they still might have a religious worldview. So if we don't inquire into the religious backgrounds of our clients and our patients as we're seeing them, we may be missing an extremely important avenue into how to help them.

And I think that Victor's case really beautifully illustrated this, where the Imam was able to guide the client to the proper care. But in Montreal on the Cultural Consultation Service again, which is where I'm working for most of these cases that I see, we have cultivated relationships with religious leaders in the community and I've been very enriched by these relationships and I've learned a lot from the people, from religious leaders.

Recently I had an Imam come accompany a client to the meeting, to the evaluation and the Imam took some time before I met with the patient just to teach me a little bit about Islam and about what kinds of problems people may face from his congregation. And in return I was able to explain a little bit about mental health problems to the Imam. It was a very mutually enriching interaction. And then we were able to talk to the client together, to the patient together I think in a better and more profound way. I think that these leaders are usually neglected. I think that most practitioners don't think about reaching out to our parallel mental health providers, religious leaders, because religious leaders see a lot of mental health problems in their congregations. They're surprisingly aware of what's happening.

And as I mentioned already, they often have very good suggestions of how to be helpful. So I think that that's something to keep in mind. It might even be helpful if you practice in an area with a lot of diversity, if there's a lot of newcomers to your country, it might be helpful to do a little survey of religious organizations in your community or around your hospital or clinic and reach out to people and

start talking to them. Takes a bit of extra time in the beginning, but I promise you it will save time in the long run if you have some context and some context dependent help you can offer your people.

We've even seen religious communities rise up to the occasion and help women who are single mothers keep their children who otherwise would've been placed in foster care. It's that dramatic sometimes and a really well resourced and a good network of friends and extended family, maybe sometimes family, but often sometimes people are alone, as we know. The network that comes from these religious communities can take care and support our efforts even to the point where a woman can continue to be with her child. And that was just so remarkable to me when that happened to us in one clinical example. So I think those are some of the thoughts I'd like to leave on this. It's an important point.

Sonya Virani:

Thank you so much Dr. Jarvis. I am so glad we had the opportunity to discuss this case and I was able to ask you these questions given your interest in religion and mental health and the intersection of them both. So thank you for those closing thoughts. And with that, we come to the end of the 10th episode of Finding Our Voice, the third one in this new second segment dedicated to issues of social determinants of mental health. Our deepest gratitude to our guests, Dr. Jarvis and Dr. Pereira Sanchez. We are so thankful for your time, the stories you discussed and the insights you provided. We really enjoyed learning from you about your various experiences with clinical and research work about the effects of war, shooting, violence and the impacts of migration and the various stressors that come before and with them. We greatly value what you have shared with us today. This discussion can certainly find a lot of application in daily clinical practice. Thank you, you both.

Dr. Pereira Sanchez:

Thank you.

Dr. Jarvis:

Thank you, Sonya.

Sonya Virani:

With that, I'd like to leave you with one final thought. Elisabeth Kubler-Ross, the celebrated Swiss American psychiatrist once said, I have never met a person whose greatest need was anything other than real, unconditional love. You can find it in a simple act of kindness towards someone who needs help. There is no mistaking love. It is the common fiber of life, the flame that heats our soul, energizes our spirit and supplies passion to our life. Thank you.

Finding our voice would not have been possible without help from Dr. Francis New, my mentor who has been on this project with me, guiding me at every step along the way. And finally, I'd also like to thank APA publishing for being instrumental in recording, editing and releasing this podcast.

Speaker 4:

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