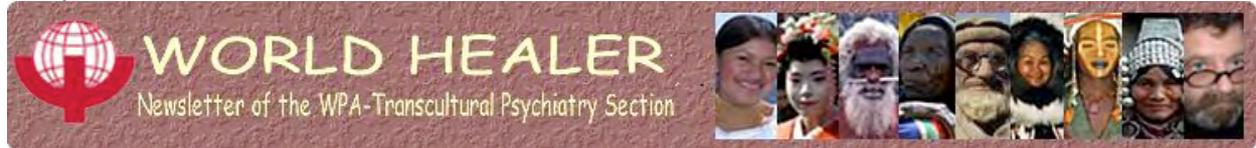


Volume 2, Number 3
July, 2007



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Contents

- Message from the WPA-TPS Newsletter Editor.....1
- Report of JSTP+WPATPS+WACP Joint Meeting in Kamakura,Japan; April 2007.....1
- Conference Report; Mental Health of the Maghrebien Patient.....4
- Bio-sketches of TPSCommittee members.....4
- Dan Lamla Mkize, M.D.....5
- Frank Kortmann, M.D., Ph.D.....6
- Joseba Achotegui Loizate M.D., Ph.D.....8
- J. David Kinzie, M.D.....9
- Kees J. Laban, M.D.....11
- Lawrence G. Wilson M.D.....14
- Samuel O. Okpaku, M.D., Ph.D.....16
- Simon Dein M.D., Ph.D.....19
- Stockholm in September; report of a planning visit, 16-22 June 2007.....20

**Message from the WPA-TPS
Newsletter Editor**

Dear Colleagues

I am very pleased to inform you that the third issue of the WPT-TPS Newsletter has just been published although there was delay of publication because the editor was so busy organizing a joint meeting in Kamakura, Japan. For my apology I put “Report of JSTP+WPATPS+WACP Joint Meeting in Kamakura, Japan; April 2007” at the top. You will also enjoy another conference report, “Mental health of the Maghrebien patient” by Dr.Joan Obiols-Llandrich. In this issue, eight fascinating “Bio-sketches” of our colleagues are uploaded. Through this popular series, I hope you will be excited to know various life experiences and culture presentations of international transcultural psychiatrists. As a final item in this issue, our Section chair, Dr. Wintrob, did a

preliminary research of the location of the Stockholm meeting that will be held in September 2007 and reported it. You must be tempted to visit Stockholm to attend this SSPC+WACP+WPATPS joint meeting.

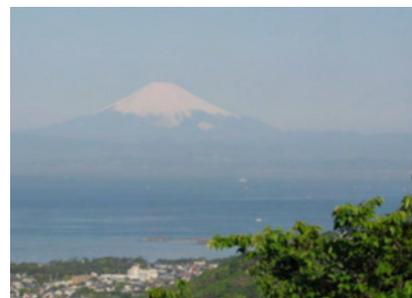
I hope all of you will enjoy reading this third issue of the WPATPS Newsletter, and also I hope to see many of you in WPATPS related conferences in near future.

Fumitaka Noda MD, PhD
Editor

**WPA-TPS NewsletteReport of
JSTP+WPATPS+WACP Joint
Meeting in Kamakura, Japan;
April 2007**

Fumitaka Noda, M.D.
**Chair of JSTP+WPATPS+WACP Joint
Meeting in Kamakura, Japan**

Everybody who visits Japan hopes to have an opportunity to see Mt Fuji. However, from spring through summer, Mt.Fuji can be moody. She often hides behind the deep clouds and rarely shows her beautiful features.



From April 27 to 29, 2007, a joint meeting of the Japanese Society of Transcultural Psychiatry/JSTP (chaired by Dr. Fumitaka Noda), World

Psychiatric Association-Transcultural Psychiatry Section/WPA-TPS (chaired by Dr. Ronald Wintrob) and World Association of Cultural Psychiatry/WACP (chaired by Dr. Wen-Shing Tseng) was held at the Shonan International Conference Center. The Center is spread across the top of a hill, a few miles from Kamakura, from which vantage point visitors can have a panoramic view of Mt. Fuji, across Sagami Bay... if the weather is ideal.



And for three days during the Joint Meeting, we were just blessed by God (or at least it seemed so). The weather was so fine and mild and the air so crystal-clear, that every conference participant could enjoy a gorgeous view of Mt.Fuji from the hilltop of Shonan Village, which, as an additional bonus, was covered in fully blossoming azaleas. The scene from the hilltop was breathtaking; as the accompanying photos show.

Table 1; Participants at the Kamakura Joint Meeting

ANDORRA	2	NETHERLAND	1
AUSTRALIA	3	NEW ZEALAND	4
BELGIUM	2	PERU	1
CANADA	14	PHILIPPINES	1
CHINA	4	SPAIN	2
FINLAND	1	SWEDEN	1
FRANCE	3	SWITZERLAND	1
GERMANY	1	UNITED KINGDOM	4
JAPAN	127	USA	25
KOREA	9		
LITHUANIA	1	Total	208
NEPAL	1		

As you see in Table 1, there were more than 200 participants at the Kamakura Joint Meeting, from all over the world. They were attracted to Kamakura for this conference at an ideal time of year in Japan, and to the main conference theme of “the new era of transcultural psychiatry: advancing collaboration of East and West”.

The scientific program of the Joint Meeting included three plenary symposia, four special lectures, three film sessions, 28 topic symposia and 21 poster presentations. Those sessions covered various aspects of the conference theme, such as multiculturalism, the psychological and social trauma of war , post-conflict reconciliation, psychiatric emergencies, alcohol dependence and abuse, cultural psychiatry issues in Asian countries, and also in Latin American countries,, womens issues, HIV and gender, social work, religion, globalization, psychotherapy, media issues and healing techniques.

Each of the three sponsoring organizations presented one plenary session.

WPA-TPS organized the first plenary symposium; “Toward multiculturalism: is biculturalism possible?”. The symposium was chaired by Dr. Wintrob and included presentations by Drs. Kamaldeep Bhui from the UK, .Bennegadi from France, John De Figueiredo from U.S.A and Wen-Shing Tseng from U.S.A, each of whom gave compelling accounts of their personal and professional life experiences of biculturalism and multiculturalism. The second plenary symposium; “Culture-related specific psychiatric syndromes: Asian examples” was organized by WACP and chaired by Dr. Sung Kil Ming from Korea and Dr.Tseng. Presentations were made by Drs. Ming and Tseng and by Dr. Katsuragawa from Japan. The third plenary symposium; “Trauma and culture” was developed by JSTP. The symposium was chaired by myself and Dr.Keisuke Tsuji from Japan. Presentations were made by by Drs.Watanabe from Japan, Ederveen from the Netherlands, Kinzie from U.S.A. and Ohyama from Japan.

Two special lectures were given by Canadian speakers with close connections to Asia.. Mr. Tatsuo Kage discussed a subject few conference participants were familiar with; “Redress for the wartime incarceration of Japanese Canadians: intergenerational conflict and cooperation” that

gave the audience new awareness of the intense humiliation and psychological turmoil caused by the internment of Canadian citizens of Japanese background, and of legal immigrants to Canada from Japan, during the years of the Second World War. Dr. Soma Ganesan proposed a new aspect of cross cultural psychiatric formulation through his presentation.

The conference's keynote speaker, Dr. Masashi Nishizono of Japan, gave a presentation on "Globalization and the meaning of psychiatry", in which he introduced the history and new movement of transcultural psychiatry in Japan and suggested how it could contribute to the advancement of global transcultural mental health.

Another unusual and fascinating lecture was given for conference participants, and made available to the public as an open forum. The speaker was Bishop Daishin Adachi, of the Engakuji Zen temple in Kamakura. He talked about the concrete application of concepts of Zen Buddhism by describing them as "a Cosmos of kokoro (mind)". The conference hall was filled to capacity for Bishop Adachi's presentation.

In the numerous topic symposia, there was a wide range of cultural psychiatry concerns addressed by the presentations, generating active exchanges of ideas in the discussion periods that followed symposium presentations. Participants told us that they were very satisfied with the quality and breadth of symposium topics and individual presentations.



The exceptional setting of Shonan Village and its resort ambience, the fine weather and the panoramic views, and the pleasures of talking with old friends and colleagues from many countries were great enticements to conference participants to stay at the Village. At the same time, the cultural attractions of historic Kamakura, with its

many monuments, shrines, temples and gardens, were only a few miles away; so many people took advantage of that proximity and visited Kamakura too.

At the gala dinner, a group from Hayama offered a performance of traditional drumming, giving the audience a glimpse of traditional Japanese arts and culture.



The farewell party was held at a marina in Hayama harbor. Participants enjoyed the abundant seafood buffet and were taken for a powerboat cruise on Sagami Bay. Our Maori colleagues from New Zealand performed several beautiful Maori songs for participants. Towards the closing of this very enjoyable event, the sun was setting over the ocean and behind Mt Fuji in a spectacular performance of nature. The sky changed steadily from blue to red, and then, as the sun set, to violet and then to silhouette. The scene was something special, that we will all remember.



I hope everybody returned to his/her home town from the Kamakura conference with re-invigorated inspiration to continue their interest and activity in cultural aspects of psychiatry., as well as with positive memories of their visit to Japan and warm feelings of friendship. That was what our local organizing committee and I , as chair of this joint meeting, aimed at.

You can review some of the content of the conference and see many of the beautiful photos of the three day event on the Internet conference site,at;<http://www.shonanvillage.co.jp/wpatcp.htm> from July through next June.

With warmest regards,

Fumitaka Noda, M.D.

Conference Report ; Mental Health of the Maghrebian Patient

Joan Obiols-Llandrich, MD, PhD.

The first Spanish (national) conference on Transcultural Psychiatry took place in Barcelona, Feb 2nd and 3rd, 2006, organized by the Department of Psychiatry of the Vall d'Hebron University Hospital in Barcelona. The focus of the

conference was on the mental health of immigrants, refugees and asylum seekers to Spain from the mainly Arabic countries of North Africa (the Maghrebian countries). This theme was a reflection of one of the main problems that Spanish psychiatrists have to confront nowadays; which is how to provide appropriate mental health care to the rapidly increasing number of Maghrebian migrants seeking treatment at psychiatric facilities throughout Spain.

Among the migrant groups, Moroccans are the most numerous in Catalonia, the autonomous region of Spain whose capital is Barcelona. So, although the Maghreb is the general term for this northwestern part of Africa encompassing countries from Mauritania to Libya, most attention was given to migrants from Morocco. Some presentations also referred to migrants from other Maghrebian countries, such as Tunisia.

The scientific program, extending from 9 am to almost 9 pm, during each day of the two day conference , was very comprehensive. Presentations ranged from geographical and historical data to clinical presentations, including sociological and anthropological aspects, such as family structure and changing social roles and the traditional mental health care system, as well as issues related to the stigma of mental illness in traditional Islamic societies of the Maghreb.

The keynote lecture of the conference was presented by the former President of the WPA, Prof JJ Lopez-Ibor, who gave an impassioned account of mental health in Al-Andalus during the time it was an Islamic province in Spain, with its capital in Grenada and the great mosque was constructed in Cordoba.

Presentations were given by distinguished Maghrebian scholars, the majority from Morocco, including Prof. Driss Moussaoui and Nadia Kadri from Casablanca and Amina Bargach from Tetuan., Other clinicians and scholars from France and Belgium, with a long tradition and extensive experience in treating Maghrebian migrants gave presentations that contributed very useful information for Spanish psychiatrists and other mental health specialists who are treating Maghrebian patients in increasing numbers.

Our fellow WPA-TPS member and colleague, Dr. Rachid Bennegadi, was one of the invited speakers, and made two very well-informed presentations on his innovative and extensive experience at the Minkowska Center in Paris.

Because the Maghrebian migration issue is raising overwhelmingly important questions at the present moment in Catalonia, one of the roundtable discussions brought together almost all of the directors of psychiatry departments of the hospitals in Catalonia, to discuss what is being done to adequately deal with this specific migrant population.

It was evident that more resources have to be devoted to their care. It also became obvious that there is a great and urgent need for training in transcultural psychiatry at all levels of mental health professionals.

The meeting was extremely successful. The presentations were at a high scientific level and at the same time, provided practical guidelines for the treatment of Maghrebian patients and their families.

It was the first time in Spain that a conference was organized with a transcultural psychiatric vision, on a subject of intense general interest at present. The response was as it deserved: a full attendance for the two days in a lecture hall big enough to accommodate 400 people.

It is worth emphasizing that the conference participants were not only psychiatrists, but included a wide range of health and mental health professionals: general practitioners, psychologists, nurses, social workers and others.

Great credit for this accomplishment has to be given to the organizers.

Prof. Miquel Casas is the Head of the Department of Psychiatry at the Vall d'Hebron Hospital and has attracted to his department a young and enthusiastic team devoted to transcultural psychiatry, including Drs. Paco Collazos, Adil Qureshi and Mar Ramos. They are, in my judgment, excellent exemplars of the new generation of Spanish transcultural psychiatry and I am confident that we will be hearing a lot from them in the future.

So, congratulations and "*adelante!*"

Bio-sketches of TPS Members



Dan Lamla Mkize, M.D.

The small village of Mzimkhulu, in the Transkei region of South Africa, was already divided along racial lines when I was born, in 1948. This is a significant year in the history of South Africa. It was the year in which the all-white Nationalist Party came into power, entrenching the laws of Apartheid.

Therefore, from an early age I grew up in a culturally divided country, in which I had limited contact with other racial groups, especially Whites, with whom interaction was mostly clouded by suspicion and hatred. In consequence it took me a long time to rid myself of the racial prejudice that I had involuntarily acquired during my developmental years, during which the primary and secondary schools that I attended were exclusively African.

My introduction to transcultural influence occurred during my experience as a medical student amongst Coloured and Indian classmates at the University of Natal.

It wasn't until my post-graduate studies, at about age forty, that I was able to develop a meaningful relationship with my White colleagues, an interaction which increased with time and led me to realise that my preconceptions and prejudices about White South Africans were misinformed.

This has led to my studies of other cultures, to my interest in cultural psychiatry and to my travels worldwide to widen my horizons.

It was during my time as a registrar at the Whites-only Townhill Hospital, that I had an intense interaction with White patients.

I remember one, a 28 year-old university student, who refused to be examined by me. He said in Afrikaans, “I won’t be examined by a black man. I am AWB” (an extremely right-wing White Afrikaans political organisation). I responded by saying “I am ANC”, which at that time was the feared, and banned, South African resistance political organisation headed by Nelson Mandela. After that encounter, he developed a respect for me (I am not sure whether it was based on fear) and I never had any more problems with him, or with other White patients.

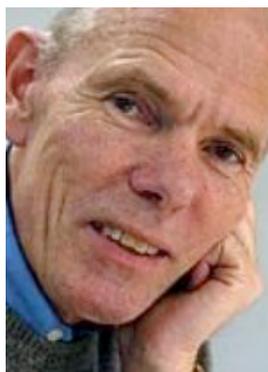
My career interest in psychiatry began in the late 1970’s, when I was a general practitioner doing sessional work at Mzimkhulu Mental Hospital. This was an institution caring for over 500 patients; with no psychiatrist. Through that experience, I saw the need to specialise, with the intention of fulfilling the role of psychiatrist at Mzimkhulu Mental Hospital, where there was such manifest need. However this was not to be, because after qualifying as a psychiatrist, I was appointed by the University of Transkei to start the Department of Psychiatry there.

My interest in cultural psychiatry, local and global, blossomed whilst doing my post-graduate studies under the mentorship of Professor W H Wessels. I was fascinated by this white person who was teaching me about my own culture and its relationship to psychiatry.

My contribution to cultural psychiatry includes a review article in the South African Medical Journal on ‘Amafufunyane – a culture-bound syndrome’, and I have given a number of presentations, both nationally and internationally, on African psychiatry and psychotherapy. My academic work includes studies of traditional healing methods, and integration of (indigenous) African health systems with Western health systems.

As my retirement approaches, I intend devoting much more time to this subject, with a view to writing a book on cultural psychiatry relevant to South Africa.

This journey would not have been possible without the support of my wife, Lungi, and our three lovely children, Lwazi, Lundelwa and Zamakhize.



Frank Kortmann, M.D., Ph.D.

I was born in 1942, in Boskoop, in The Netherlands. I am the 10th and youngest child of a traditional roman catholic family. My father had a nursery. I studied medicine at the State University in Groningen and fulfilled a rotating internship in Worcester City Hospital in Worcester Massachusetts, USA. Back in The Netherlands I specialised in psychiatry and was for eight years teaching in the Department of Psychiatry of the University of Groningen. At the same time I started my psychoanalytical training. After ten years of psychoanalysis and therefore being bound to the place where my psychoanalyst was living, I felt a strong urge to broaden my scope. It happened that one of my fellow teachers in Groningen was Robert Giel. He was strongly engaged in psychiatry in Ethiopia, especially in the introduction of this subject in the medical curriculum of Addis Ababa University in Ethiopia. He invited me to take the position of Associate Professor in Psychiatry in Addis Ababa University. Quite unprepared I jumped into this adventure. There I fell in love with transcultural psychiatry. This has never left me anymore. My psychoanalytic background might have been an important factor for my choice for this speciality, because transcultural psychiatry and psychoanalysis have much in common. The basic attitude of the therapist is an anthropological one in both. There is always a cultural gap between the psychiatrist and the patient. In order to understand the patient and to feel empathy for him or her, the therapist has to have a genuine attitude of interest and curiosity. In this relationship of interest the patient feels respected, known and understood, which might be the most important factor for compliance to treatment.

For two years I was teaching Ethiopian students’ psychiatry. I treated many Ethiopian patients in an

OPD, together with the students. Now I realise that the students were teaching me sometimes even more than I did to them. In Ethiopia I also got to know the instruments of WHO for the implementation of mental health care in primary care in developing countries. One of these instruments is the so called Self Reporting Questionnaire (SRQ). At that time WHO pretended that the SRQ was applicable all over the world, regardless the culture of the patient. I was curious to know whether this was true for Ethiopia. So I started some research on the validation of the SRQ and found out that the claim of the WHO was too pretentious. I wrote my PhD-thesis on this subject and a number of articles.

After coming back to The Netherlands, I change the type of work completely. For seven years I was general and medical director in psychiatric hospital 'Wolfheze' (840 beds), now 'De Gelderse Roos'. In that period a specialized centre for asylum seekers and refugees with psychiatric problems was opened in that hospital. That gave me the opportunity to keep in touch with transcultural psychiatry.

In 1993 I became professor in General Psychiatry in the University of Nijmegen in The Netherlands. I was the chairman of the Department of Psychiatry and Director of the psychiatric residency training. After seven years I felt the strong urge to exchange my management tasks for a type of work that was more close to transcultural psychiatry. I got a professorship in Transcultural Psychiatry. My main cause for my change in work was that I saw many non-western patients in The Netherlands who quit the treatment against advice because of a poor relationship with their mental health workers. I became more and more interested in the causes for it. In many supervisions I learned that my supervisors realised that things went not as it should be with their patients, but that they could not pinpoint what the reason was for it. Therefore it was difficult for them to think of methods for improvement. I realized gradually that there was hardly any theoretical basis for transcultural psychiatry. Developing a theoretical frame of reference for transcultural psychiatry became my main point of interest during this professorship. I wrote a Dutch textbook "*Transculturele Psychiatrie. Van praktijk naar theorie*" (Transcultural Psychiatry. From Practice to Theory), that can be used in teaching, training and research.

Up until now my professorship in Transcultural Psychiatry is the first and only one of that kind in The Netherlands. One of the reasons is that academic psychiatry focus more and more on biological issues for many reasons. One is a methodological one. Many researchers avoid research in transcultural psychiatry because of the difficulties they may encounter in the methodology. That may lessen the chance to get their articles publicized in international journals.

At that time we established a section 'Transcultural Psychiatry' in the Dutch Psychiatric Association, to put this very important subject more on the agenda. I became the first chairman of that section. I did a lot of training and supervision on transcultural psychiatry, as there was a increasing need for it, due to the great influx of immigrants at that time from Turkey, Morocco, Suriname and The Netherlands Antilles in The Netherlands.

At the same time I shifted my focus of attention also to third world countries. I assisted national and local authorities in designing mental health plans and trained many non-western doctors and other mental health workers in implementing some basic mental health care in primary care. Being single it was quite easy for me to work in East Timor, Cambodia, Nepal, Afghanistan, Jemen, Turkey, Bosnia, Kosovo, Suriname, Sierra Leone and Ethiopia. My employers were mainly WHO and international NGOs.

I kept a special tie with Ethiopia. Four years ago a residency training in psychiatry was started in Addis Ababa. The majority of trainers were recruited from Canada. But for the training in psychotherapy the Ethiopian Department of Psychiatry invited me, being a psychotherapist, to do the teaching and supervision of the residents because I knew the Ethiopian culture to a certain extent. For me this was the ultimate challenge in transcultural psychiatry in my life.

Recently I am also part time working as psychotherapist especially for non-western mentally ill offenders in a forensic psychiatric clinic in The Netherlands.

After being involved in transcultural psychiatry for many years, I became more and more convinced that *all psychiatry is transcultural psychiatry*, as there is always a cultural gap between the doctor and the patient. Therefore what I am teaching and practicing is just ordinary normal psychiatry!



Joseba Achotegui Loizate M.D., Ph.D

I was born in Bilbao in 1952, in the Basque country of Spain. I was educated at Jesuit primary and secondary schools.

I studied medicine at the University of Barcelona, where I obtained the title of specialist in psychiatry, with top honours. In 1990, I obtained my doctorate, cum laude, in Medicine at the University of the Basque Region. My thesis was titled “Comparative analysis of the ego concept in the works of Melanie Klein and Heinz Hartmann”.

During my training in transcultural psychiatry I have been influenced by Dr. Jordi Font and Dr. Jorge Tizón, two psychiatrists who, in the 1980s, showed great sensitivity to this subject, that was extremely undervalued in Spain at that time. Dr. Font’s work on the mental health of Spaniards emigrating to Germany was particularly notable. Dr. Tizón, carried out important research on immigrants moving from the south of Spain to Catalonia. Drs Tizon and Font founded the CIPP (Psychopathological and Psychosocial Research Group), in which I received training and worked. CIPP was the predecessor of SAPPPIR, where I am currently working.

I would also highlight the training I received from Doctors León and Rebeca Grinberg, who immigrated to Spain from Argentina at the end of the 1970s; particularly for their contributions to grief related to migration. I also have been strongly influenced by the training experiences I had at the Minkowska Centre in Paris, during the late 1980s, and with which I have maintained close contact ever since.

In 1991, I was appointed Professor of Psychotherapy at the University of Barcelona. I have continued in this position ever since.

I have basically done clinical work and conducted research in the area of migration and mental health.

During my career as a cultural psychiatrist, I have been fortunate to work in collaboration with the psychiatrist Dr. Dori Espeso, whose expertise is with immigrant minors, and with the social worker Nuria Pellejero, who has in-depth knowledge of the social problems related to migration, and Dr. Anna Tuset, a psychologist expert in transcultural assessment.

- since 1982, I have been a member of the CIPP (Psychopathological and Psychosociological Research Group) of the Vidal and Barraquer Foundation in Barcelona, specialising in migration and mental health. In 1987, this group obtained a research award from the Spanish Neuropsychiatry Society for the project; “Migration and Mental Health”. The study was subsequently published in 1993, by the University of Barcelona Press, under this same title.

- in 1994 I founded and, since then, have been the director, of SAPPPIR (Psychopathological and Psychosocial Assistance Service for Immigrants and Refugees) at the Hospital Sant Pere Claver, in Barcelona.

- in 1997 I was given the Solidarity Award by the Catalan Regional Parliament, for my work with immigrants.

- since 1971 I have been the director of the post-graduate course “Mental health and psychological interventions with immigrants, refugees and minority groups” at the University of Barcelona.

- from 1998 through 2004 I have been advisor on issues regarding migration and family regrouping for the European Parliamentary Committee on Citizens’ Freedoms and Rights

- I am the coordinator of the international task force on “The Ulysses Syndrome”, sponsored by the European Parliamentary Committee on Citizens’ Freedoms and Rights

I am grateful to the administration of the Sant Pere Claver Hospital, in which SAPPPIR is located, in the port area of Barcelona. SAPPPIR was created specifically to deal with the mental health problems of the immigrant population and with those who are socially excluded, and has always supported our work with these populations.

My work in the area of migration and mental health has led to my publishing a book titled, *Depression in Immigrants: a trans-cultural viewpoint*. Ediciones Mayo, Barcelona. 2002. This book describes “the Ulysses Syndrome” for the first time.

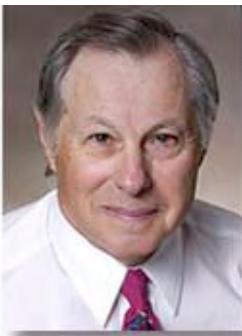
I have also been editor of *Anxiety and Depression in Immigrants*, published in 2003 by Ediciones Mayo, Barcelona, and, *Chronic Stress: clinical and therapeutic aspects*; Ediciones Mayo (in press).

The Ulysses Syndrome

The concept of the Ulysses Syndrome, that I first described in 2002, has led to the following works since its publication in the book *Depression in Immigrants*:

- the novel “the Ulysses Syndrome” by Santiago Gamboa, regarding the suffering of South American immigrants in Paris. Publisher: Seix Barral, 2005.
- a book of poetry “Ulysses Syndrome” by Arsenio Rodríguez Quintana, a Cuban poet, published in 2004.
- two plays titled “Ulysses Syndrome” – one in Spain and the other in Mexico, in 2005
- an art exhibition in Barcelona in May 2006

I have been a member and an active participant in the conferences of both WPA-TPS and WACP; including presentations at the conferences in Vienna in Apr 2006, the first World congress of Psychiatry, in Beijing, in Sep 2006, and the jointly-sponsored conference in Kamakura in Apr 2007.



J. David Kinzie, M.D.

My Life in Cultural Psychiatry

I have had an exciting and interesting life in Cultural Psychiatry, both in being able to treat, and work with, patients from a variety of cultures, as well as to work with colleagues from around the world.

My first such experience was as a general physician in Vietnam, during the escalating Vietnam War. Treating the profoundly sick and wounded was a difficult and life-changing experience. This experience introduced me to the complexities of problems of war and refugees. Later, I worked with Aborigines in Malaysia and helped take care of isolated tribes throughout the Malaysian peninsula. This was a unique experience of providing medical treatment to unsophisticated and very reserved Aborigines, some of whom suffered from profound psychiatric disorders.

During my psychiatry residency training years, I worked with Jim Shore, doing an epidemiological study of an Indian village. Later, I returned to Malaysia to teach psychiatry at the new medical school in Kuala Lumpur. I worked with Eng Seong Tan, chairman of the Department of Psychological Medicine. While there, I wrote several articles on psychiatric disorders among the Aborigines, on cross-cultural psychiatry and on cross cultural psychotherapy; articles that stimulated my interest in cultural psychiatry and psychiatric problems in developing countries.

Later, I worked at the cross-cultural setting of the University of Hawaii Medical School, where I was able to treat patients from the many different cultures of Hawaii. This was also a very fruitful and enjoyable time, collaborating with colleagues Wen-Shing Tseng and Jing Hsu.

Since 1976, I have been a faculty member of the Department of Psychiatry at Oregon Health and Science University, where one of my first responsibilities was to develop an Intercultural Psychiatric Program. That program started by treating refugees from the Indo-China War. We used the model of an ethnic counselor teamed with a psychiatrist, to treat patients from a specific culture. Throughout much of this time, Jim Boehnlein and Paul Leung joined me and ten other psychiatrists, to accommodate refugees from sixteen different language groups.

The academic work has been very productive; involving cross-cultural psychotherapy, clinical treatment programs, development of the Vietnamese Depression Scale (with Spero Manson) and post traumatic stress disorder among the Cambodian concentration camp survivors. With Bill Sack, we were able to study the effects of massive trauma on Cambodian children, in a community epidemiological study. Specific work at this time involved testing blood levels of the patients. We found that blood levels of antidepressants indicated non-compliance. We also described the benefits of clonidine for PTSD, and of group therapy for traumatized refugees.

A side benefit of working with Paul Leung, Jim Boehnlein and Spero Manson was to restudy the same Indian village where we had done a field study 19 years previously. We found there was a remission rate of alcohol dependence of about 50% over that time.

More recently I have been involved in studying the psychological effects of the horrific events of September 11, 2001 on traumatized refugees, a great many of whom experienced a reactivation of symptoms; particularly among Muslim patients.

The Intercultural Psychiatric Program now has 1,200 patients, 10 psychiatrists and 18 counselors. It also has a component for child psychiatry. I personally have continued to treat patients from Cambodia, Somalia, Bosnia and Guatemala.

As I review my clinical life over the last 40 years, I have many fragmented memories that stand out. Like my patients, it is often difficult for me to put them in a coherent frame of reference.

There were the children dying of dehydration in Vietnam. One week I lost five children before we learned to adequately hydrate them. And then there was the indiscriminate killing of villagers, by who knows who, as they came into our hospital wounded. At one time, there were twenty dead piled up in our ward. There were the frightened soldiers who were shaking, angry, and with marked startle response. We diagnosed it as anxiety then, not yet having a PTSD diagnosis at that time.

In a remote aboriginal village there was a psychotic woman who was placed in a cage to

prevent her aggressive outbursts. Her husband had to force his way in and give her food forcefully, accompanied by numerous personal threats and beatings; just to keep her alive. There was the young woman who seemed to have malaria - like everyone else in the hospital - only her fever didn't go down; and it wasn't until the day after she died that we were able to diagnose it as meningitis. There was the depressed Malay woman whose mother promised her wealth if she married a rich old man. Her story turned pathetically sad when he gambled away all the money and did not die.

There was a Chinese man whose relative was very ill. The local medicine man said that it was a very serious illness and that the only way to cure him was to kill a tiger and administer some of the tiger's sperm to him. I think about another Chinese man, who had been a brilliant student in the US, who developed delusions and hallucinations that would not stop and, on his second attempt, committed suicide. And there was the civil rights worker in the US, who made many bus trips to the South during the era of racial segregation there, who frequently had to confront angry crowds and police taunting, and was left with a cruel anger simmering underneath, in all his interactions.

The stories of the Cambodians seemed to be similar, familiar and extremely distressing; starvation of children, murder of family members, torture, lack of medical treatment, and endless, meaningless, imposed physical labor. They came to us emotionally blunted and avoidant of almost all human emotions. There's the Vietnamese woman who appeared very depressed because her husband was killed during the Vietnam war, except that when the interpreter was gone, she showed me the wounds caused by the time her husband had thrown boiling water over her. In fact, she was happy that he died, but unable to express it.

There was the tragedy in Somalia with random violence. It was difficult to know who was the enemy and who was a friend. A woman described running away with her daughter, both having wounds in their legs; looking back and seeing a locked house being set afire - and realizing her son was still inside. From all the wars, Cambodia, Bosnia and Somalia, the missing and unaccounted

for continue to give distress to all those who survived. With the current forensic evaluations of bodies in Bosnia, many of those survivors have had to face the reality that their husbands and brothers have, indeed, been murdered, and the cherished fantasies of their returning are no longer tenable.

At these times, culture seems relatively unimportant. It is the human condition itself that is frustrating and unpredictable. For the psychiatrist, there is often nothing else to do except stay with the patients, listen to their stories, offer understanding, empathy and support. The contact between people of various cultures seems to be the healing element. It is in experiencing the joy of people getting well and the resilience of people overcoming trauma, that we, the treating personnel, find some of our most intense professional rewards.

For me, the psychiatric experience has been a very fruitful family affair. One son, Erik, who lived in Japan and speaks Japanese, is a psychiatrist in Charlotte, North Carolina. Another son, Mark, has joined me in the Department of Psychiatry at OHSU and is now leading a Torture Treatment Program. My wife, Cris Riley, has been an active collaborator in the research projects and many special programs. I am very happy to be associated with the Intercultural Psychiatric Program, to be able to work with patients from around the world. They have constantly brought me joy and amazement at the resiliency of the human spirit. It is a unique privilege and responsibility to share in the lives of traumatized refugees, and hopefully to reduce their suffering.



Kees J. Laban, M.D.

When I was asked to contribute a bio-sketch for the Newsletter, my memories went back to the last evening of the cultural psychiatry conference in Rhode Island in Oct 2004. At the farewell diner the atmosphere was very pleasant. Probably inspired by this atmosphere and by the afternoon symposium, in which four participants (Ron Wintrob, Mitchell Weiss, Riyadh Al-Baldawi and Michael Hollifield) told their life story, a group of residents invited several guests to sit at their table and tell their life story connected to transcultural psychiatry. I was one of those invited.

To my own surprise, I started my story by telling my audience that I was born thanks to Hitler. That attracted their attention and I started to explain: a year before World War II, young men in Holland were recruited into the army. My father volunteered. He was assigned a managerial job and was sent to another part of the country. Because there were not enough barracks, he was housed with civilians. And, as you may have guessed, my mother was part of the family that my father was sent to live with. They married in 1944 and I was always told that when my oldest brother was one month old, he saw the “tommies” (Canadians, English, Americans) parachuting food packages above Rotterdam: the hunger was over!

I was born in 1953, the fourth of five children. In addition to the war, different types of Christian faith have influenced my life. My father was raised in a very liberal family, while my mother was from a very conservative Calvinistic family. My father adopted the lifestyle of my mother after their marriage, which had serious implications for us as children: no outdoor activities, no sports, no bike riding on Sundays, and no dancing, no going to cinemas or street fairs, and even no Christmas tree.

Notwithstanding all these constraints, I received a lot of love; although I didn't realize that at the time. There was one interest that my mother and I had in common: Africa. She was active in the Christian mission movement and my interest in this faraway, strange world grew through her influence. My father continued his military service in Indonesia for three years shortly after the war, but he avoided talking much about his military life.

During my puberty, I rebelled a lot against all the limitations and rules my parents imposed on us

children, and I think from that time on opposition became my second nature, my being in life. Later on I saw the parallel between my life experience and the context of the times in the western world. There was a lot of opposition around me: student revolt in Paris, marches against Vietnam, freedom fighters against their colonial masters. My interest in politics grew and I defended the left wings ideas; even in the church group. In school and university we discussed the future of the world, how to limit the power of capitalism and how to make things better and wealth be more equally shared.

In the meantime, faith had come back in my life. I met a group of evangelical Christians who showed me that it was possible to be a Christian and still have a happy life. I joined an evangelical student association and was quite active in that organization for some years, being energized by some deep religious experiences. I tried to integrate my political ideas with this new-found faith. Accordingly, I joined a movement called 'religious socialists'.

During my medical training at the University of Utrecht, from 1974-1981, psychiatry attracted my main interest - especially the so-called anti-psychiatry movement, of course - but I was determined to become a tropical doctor. A year-long program in Cultural Anthropology and Medical Sociology at the University of Leiden made me even more motivated.

During that time, I found the love of my life and told her that if she wanted to share her life with me, she should accept going to Africa with me. Fortunately, she shared this interest with me and became active in the 'third world movement'. We demonstrated together in Amsterdam against nuclear missiles, and were proud that the opposition against these missiles was called "the Dutch Disease".

To prepare myself for working in the tropics, I worked (1982-83) as a resident in gynecology, surgery and internal medicine, and participated in a 3-month course at the Royal Tropical Institute in Amsterdam. In September 1983, we -my wife, our son and me- went to Nigeria: to Cross River State, an Ibibio area that included a large number of tribes and languages.

We went to the tropics accompanied by the shame of colonial times and its past history of white superiority. In the area we came to, however, the people who lived there had only very good experiences with whites, and we were well accepted from the beginning. Also all our political concepts and ideas became completely irrelevant in this environment and nobody was interested in hearing about them - nuclear missiles were no issue in that part of Nigeria.

Next to my culture shock in adapting to living in Nigeria, this was my main shock: a complete identity switch, or is it better so see this as part of the overall culture shock?

My own faith had moved in a more ecumenical direction in the several years before going to Nigeria, but this also became irrelevant, at least in the world outside our doors. Because the hospital was attached to the Lutheran church, we became familiar with the Lutheran faith. The local interpretation of this faith was: everything that happens is the will of God, so if your child dies, or if your village is infected Guinea worm, there is nothing you can do about it. No opposition and no search for how things could become better.

Fortunately, the urge to live and to protect your children is universal and strong, and in daily life a lot of people worked to make things better. Most health workers had an attitude of helping and cooperating. In addition to my work in the hospital, I was the head of the primary health care program, and the tuberculosis program. These responsibilities brought me to a wide variety of villages and tribes. I sat down with village heads and women's groups, talking about clinics, mother and child care programs and water wells. I did hernia surgery on a kitchen table, to compete with private practitioners who were surgically incompetent, cried about lives lost, wrote many proposals and reports, organized training programs, celebrated weddings and funerals (big ones), survived a major allergic reaction to an ant bite, had another child, was in the news because of a yellow fever outbreak, worked collaboratively with local healers (to the dismay of the Nigerian director), spent holidays in Kenya and Togo. I had no time for research, which was another thing that seemed completely irrelevant in this environment.

After five years in Nigeria, we went back to the Netherlands in 1988. I worked for a while with an

association against leprosy and tuberculosis and spent some time in Kenya and Tanzania with that organization, to evaluate several clinical programs. They had offered me a job in Nairobi, but this did not work out. My wife and children were getting settled in Holland and I had to accept that my career in tropical medicine had to come to an end.

Professionally, I was confused about what to do next. I had developed some interest in public health matters and there was a movement started by the WHO called 'healthy cities', which was directed to limit health differences related to 'socio-economic status'. Rotterdam, my birthplace, had joined this movement, and I got a job in the youth department. I did some research, attended courses in epidemiology, set up a network between school doctors, counselors and social workers, and served as a part-time school doctor in districts with large populations of immigrants. This job offered me several opportunities: to adjust to a Dutch working environment, to develop more skills in immigrant health issues and to do some scientific work.

I re-evaluated my professional life, and more and more I came to the conclusion that my real satisfaction was working with patients. My interest in psychiatry was revitalized by the contacts with adolescents and their parents, and I decided to apply for a job in this field.

My first weeks in the psychiatric intensive care unit in Deventer (1992) are still very fresh in my memory; what a change! Another type of 'culture shock' experience. A year later, I was able to enter the official training program, just by luck, I think. The hospital had applied for years to be recognized as a training hospital and suddenly they succeeded. I got the chance to enter the training program in psychiatry. By that time I knew that psychiatry was my field of medical work. I eagerly started to read psychiatry books and articles and worked to improve my skills in making contact with all kinds of patients.

During my training, I spent my 'elective period' in a service treating asylum seekers and refugees (Phoenix) and worked with Martin Kooiman. He was a very experienced psychiatrist and was very skilled in making contact with people and at the same time collecting enough information to make a good psychiatric evaluation. Transcultural

psychiatry had entered my life, as a very natural development to the next phase.

My work with my present employer, a community mental health institute in the northern part of Holland, started in 1999. My assignments were to set up a mental health program for asylum seekers, and to organize a transcultural psychiatry training program. I wrote a plan and proposed that I would not see patients myself, because I wanted to set up a system in which a large number of people were challenged and trained to work with asylum seekers. They agreed, and so for my own clinical work, I worked with an organization for refugees in Amsterdam (Pharos).

After three years the management asked me to set up a day clinic for asylum seekers and refugees. We put together a treatment team, and after a while De Evenaar (The Equator) was inaugurated (easily written, but everyone knows the process is more complicated). I became the psychiatrist in charge, ended my job in Amsterdam and my family and I moved up north. Patients come from all over the three northern provinces of the Netherlands and recently we got permission to expand to a 'Center for Transcultural Psychiatry' and open an out-patient clinic for immigrant adults, children and adolescents. The Center is also involved in training of psychiatrists, and I am a teacher of transcultural psychiatry in the general psychiatry training program for residents.

The job also gave me the opportunity to set up an epidemiological study among asylum seekers and refugees. I had already made contact with Prof Joop de Jong, at the Vrije Universiteit Amsterdam, with the aim of incorporating this study as research for a doctorate, and if all goes well, I will get my PhD in 2007. My collaborators in this study are Hajo Gernaat (also ex-tropical doctor, good analytic mind, good questions) and Ivan Komproe (knows everything about statistics and knows how to explain it), Both have been very helpful to me.

In this study, almost 300 Iraqi asylum seekers and 90 Iraqi refugees were interviewed. Outcome measures are: psychiatric problems, quality of life, disability, physical health and service use, while a broad range of pre-and post migration risk factors were investigated. The study especially focuses on the impact of the lengthy asylum procedure.

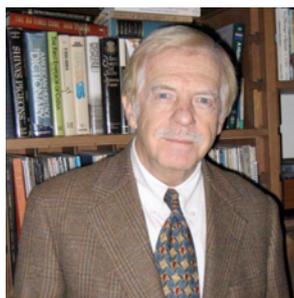
I have been able to publish several articles about the study and to present the findings at several conferences and symposia (among them; Rhode Island in 2004, Cairo in 2005, Beijing in 2006). The results have been summarized recently in a report to the Dutch government, emphasizing that the Netherlands' very restrictive asylum policy has a very negative impact on health.

Meeting with people attending the cultural psychiatry conferences has been very stimulating for me; especially the first such conference I participated in (Rhode Island). I felt honored that my presentation was in a session chaired by Joseph Westermeyer and I met many colleagues with common interest in the scientific TP field, including: Michael Hollifield (right away we made plans to set up a multi-site study), Mitchell Weiss, with his splendid ideas about combining quantitative and qualitative research, and Solvig Ekblad, whom I admire for her work in Sweden. Later on I met Derrick Silove, from Australia, who has an ongoing energy (together with Zachary Steel) to collect information about the health status of asylum seekers and advocate for them with government agencies.

The work with asylum seekers and refugees is challenging and rewarding, but sometimes not easy, as you all know. To do this work several things have been important to me: my tendency to oppose and not to sit back when injustice is done, my loving wife and children, my faith in a loving God, my friends, and my hobby (singing).

In addition to all these supportive resources, there is one more I would like to mention; the feeling of being connected to a wider network of people who share the same interest and (com)passion throughout the world. This is a very important source of inspiration for me to continue both my clinical and research work.

I thank you for providing such a world-wide network.



Lawrence G. Wilson M.D.

When I was a bright-eyed and bushy-tailed youngster in a small town in the U.S. Midwest, there was little to suggest that I might become interested in psychiatry, and certainly very little to predict an interest in cultural and ethnic issues. My relatives were mainly farm people, but my father had become a chemist and his work for Mobil Oil Co. introduced our family to some interesting experiences during my teenage years.

I ventured off to the University of Kansas, and while a history major, got interested in medicine and ventured further into the world by going to the University of Kansas School of Medicine in Kansas City. With the Vietnam situation getting more tense, after graduation in 1966 I decided to intern in the U.S. Public Health Service to give me access to medical positions in the Indian Health Service after internship, to avoid being drafted to serve as a military doctor in the Vietnam war. But, at the end of my internship, I found that I could satisfy my military obligation by serving as a physician in the American Peace Corps, so I applied and was selected. I had gotten married to my wife Janet just after medical school, and she was an enthusiastic partner in this Peace Corps venture and we sallied forth to Washington, D.C. for training.

We got assigned to work in Nepal, me the Peace Corps doctor and Jan working first as a volunteer in a leprosy clinic and later an elementary teacher in the International School in Kathmandu. I enjoyed my first "real doctor" experience for the young Peace Corps volunteers. I delighted in trekking around the hills of Nepal to visit them, give them gamma globulin injections to protect against hepatitis, and to get to know something about the different tribal peoples of both the Nepalese hills and the plains of the upper Ganges river. I got my first taste of being a physician who

could take the time to talk to my patients and get to really know them as people. Jan and I also had a chance to take off on a 3 week trip through Asia in 1968 and visit India, Thailand, Malaysia, Hong Kong and Cambodia. This whetted my appetite to learn more about the world, preferably working as a doctor along the way. Our first daughter was born in a missionary hospital in Kathmandu at the end of our Nepal assignment.

After finishing Peace Corps, I returned to Portland, Oregon to begin an Internal Medicine residency but quickly realized I was more suited to psychiatry and the more personal relationship you can have with your patient. We moved to Seattle and I began my residency in psychiatry at the University of Washington Medical School. I followed the Community Psychiatry/Transcultural track and as a Senior Resident was able to do some research on American Indian alcoholism with Jim Shore who was at the University of Oregon. After finishing residency training, I joined the faculty at U.W. and began in the clinician/teacher/scholar pathway, but always found a way, on inpatient services or Consultation/Liaison (C/L) services to integrate teaching about cultural and ethnic factors into day-to-day practical clinical problem solving. Luckily, Arthur Kleinman came to my department in the mid-70s and I was able to attend his multidisciplinary seminars for anthropologists and mental health professionals.

In 1976, I took a leave of absence from the U.W. to become Chief of Mental Health Services for the Trust Territory of the Pacific Islands (Micronesia), living in Saipan in the far Western Pacific. This was intriguing work and took me all over the islands of the "American Pacific" such as Truk, Yap, Palau, the Marshall Islands and others. I became fascinated with the variety of the Pacific island peoples. I did clinical work and teaching, but also saw the need for good psychiatric consultation to the legal system in developing and remote areas. Data that I collected during 1976-78 became the basis for a number of papers written about interesting clinical and cultural challenges of practicing and teaching psychiatry in that huge and remote area of the globe. 1978 to 1983 were years of continuing faculty involvement in traditional ways at U.W., with research collaboration and writing papers. A chance for a sabbatical year arose in 1983, and our family went

to New Zealand where I was visiting faculty at the Christchurch Clinical School of Medicine in Christchurch, on the South Island. (My luck again: Ron Wintrob had suggested Christchurch as a welcoming and invigorating place for an academic sabbatical.) I worked with many bright "Kiwi" clinician- researchers, taught the registrars on the C/L service of a public teaching hospital, and learned about the health problems of the Maori people. I also observed up close New Zealand's fine health care system.

The second half of that sabbatical year was in The People's Republic of China doing research for two months at the Hunan Medical College (now Central South University) in Changsha, Hunan province. An esteemed Chinese academic, Prof. Derson Young, had been in Seattle at the U.W. as one of the first Chinese psychiatrists allowed to come to the West to study in the early 80s. After our connection in Seattle, Prof. Young became my colleague in China for my research on the differences in symptoms between psychotic patients in China and the U.S. After two months in Hunan, our family traveled widely in China and returned for a visit to Nepal to show our daughters the locale of our early married life and Peace Corps work.

After return to Seattle in 1984, I resumed the active faculty life, assuming the directorship of a very busy C/L service at U.W.'s busiest teaching hospital. In addition to the clinical and teaching demands of that position, I was asked by the W.H.O. to visit some Pacific and Asian areas as a "Short-term Mental Health Consultant". Over the next several years I consulted in Fiji, Tonga, Cambodia and twice in Saipan. These assignments presented the same challenge I had faced in Micronesia in the late 70s: How do less developed countries bring quality mental health care to populations (sometimes very small) in widely dispersed areas with very meager resources? Later, I was asked to visit the Fiji School of Medicine in Suva and help develop a curriculum in behavioral sciences.

From 1984 to 2004, the C/L service and its demands back at my University of Washington department continued to engage me for most days and months. Although suicide attempts, delirium in post surgical and medical patients, and depression across the life span was the everyday

bread and butter of C/L work, there was enough multicultural variety in Seattle to keep things very interesting. It was my conviction that on a daily basis, a cultural or ethnic feature of a case probably would add a challenging and sometimes exotic teaching dimension to what on the surface was a mundane or “everyday” clinical situation.

In the last several years, I have been able to take time off from faculty work to do temporary teaching at medical schools in the developing world. In 2005, I went back to the Fiji School of Medicine for two months of work with 5th and 6th year medical students in their psychiatry rotations. Since mid-2006, I have been part-time in my work in Seattle and able to think about more overseas travel and projects. In January 2007, I went for two weeks to the University of Phnom Penh Medical School in Cambodia at the invitation of the Dean who I had gotten to know when he had done post-doctoral studies in Seattle. This time, work was within the school’s psychiatry curriculum for psychiatry residents and some graduate psychiatrists, with the topics ones they had chosen. Eager students and receptive doctors made the visit another wonderful experience of international transcultural psychiatry teaching, with learning decidedly going in both directions.

I have been extremely fortunate to have had contact with some of the people who have shaped Cultural Psychiatry over the past thirty years. H.B.M. Murphy, Arthur Kleinman, Jim Boehnlein, Ron Wintrob, Dave Kinzie and many others have contributed much to our field with their creative minds and devoted scholarship. I have benefited by going to annual Society for the Study of Psychiatry and Culture meetings (as well as others) and hearing the brilliant theoretical minds of such people as Laurence Kirmayer and reading his papers and analyses in “Transcultural Psychiatry”. My contributions to this field have certainly been commonplace. Yet, cultural psychiatry and international psychiatry need the practical and the applied as well as the theoretical and the abstract. Our field has room for all kinds of investigators and clinician/teachers. I have been lucky to have found a niche in this area and to have grown professionally by hearing and reading the work of the broad group of scholar-clinicians that our field has produced over these past few decades.



Samuel O. Okpaku, M.D., Ph.D

I was born in Sapele, a port city in the Niger Delta of Nigeria. The images of my growing up include tractors hauling large hardwood logs from the surrounding forests to the waterfront and flotillas of logs tied into rafts, which were then navigated downstream, to be loaded onto ships that carried them to Europe.

Born into a large family, I grew up in an environment of caring and affection, one in which education for all of us, boys and girls, was of the utmost importance. Our parents, themselves educated, sent us to the best schools and provided the best teachers for us. We had uncles and cousins who had studied in Europe. We were surrounded by books, and it is no surprise that my younger brother, Dr. Joseph Okpaku, Sr., became a book publisher early in his career. There were many books on anatomy and midwifery in our house, as our mother was a midwife.

Our father loved music and played the organ. And although I was not allowed to play our organ because of fear that I might damage the pedals, I somehow managed to satisfy the curiosity I had for musical instruments. This interest carried through to the years I was in boarding school, where I played the recorder and was pianist at morning assemblies and musical plays staged by students in my years in medical school, where I was sometimes mistaken as a music student. Our father always said that “a home without music was not a home”. The result is that I, as well as a number of my siblings, have grand pianos in our homes and play frequently.

There were also several magazines available to us at home, including *Psychology Today*, which belonged to one of my uncles. With all this exposure, and with my mother and one of my

aunts as midwives, and later, with my first cousin becoming a very well known young surgeon in Nigeria, I somehow knew, by age ten, that I would become a physician myself.

Growing up, we had a good number of mentors and role models, most important of them being our parents (my father was a civil servant), aunts and uncles (lawyers and politicians amongst them), teachers, close relatives and neighbors. They taught us hard work and diligence, self-confidence, good manners and courtesy in all circumstances, respect for our elders, generosity and magnanimity. They gave us a profound sense that there was nothing that we could not succeed at, if we worked hard to achieve our aims. This provided a deep sense of destiny, of family values and the strength inherent in a family that stands together.

As the first son in the family, I was the heir apparent. In our culture, this meant enormous responsibility, especially the knowledge that if anything happened to our parents I would have to take charge of the family's well-being. This tradition profoundly shaped my sense of destiny and responsibility that has become a permanent part of my psyche and worldview.

After completing advanced secondary education in 1961, at one of the elite boarding schools in Nigeria, I was awarded several scholarships to study overseas. At the Independence of Nigeria from British rule in 1960, education was the foremost priority of the new government. Many foreign governments offered scholarships to Nigerians to study at their universities, as part of their diplomatic strategy to build close ties with the new nation, the most populous in sub-Saharan Africa.

One scholarship I received was to study music in Europe, and another to study medicine in Israel. So, in the summer of 1962, I left for Israel; to study at the Hadassah Medical School of Hebrew University. In those days, we knew little or nothing of the Arab-Israeli conflict. The Israel we imagined was biblical. I was soon to experience the reality of conflict and the lessons of fortitude, human endurance and sacrifice on both sides, along with the plight of European émigrés and Palestinian refugees. I was particularly struck by the Yad Vashem (the Holocaust Memorial). The

suffering of the Holocaust victims seemed beyond comprehension.

But somehow I enjoyed much of the time spent in Israel, especially my visits to the kibbutzim. I took every opportunity I could to spend time at the Givat Haim kibbutz, close to Nathanya. But the tension from the conflict was already palpable and not conducive to a relaxed academic experience with the freedom to mix with everyone and to come and go without fear of violence. Things were becoming quite tense, and they were to escalate to new heights a few years later.

I had always dreamed of studying at Edinburgh University, and when the opportunity came, I took it. WHO, which was sponsoring my scholarship, had promised me that they would support a transfer to Edinburgh University as long as it did not mean the loss of an academic year. But, to my surprise, they reneged on the commitment. I imagine that they presumed that without scholarship funds, I would be unable to go to Edinburgh. But we have been raised to rely on ourselves and to be prepared to work hard for our dreams. With the approval and blessing of my parents, I went to Edinburgh.

That summer, I worked as a nurse, sometimes doing three shifts in a row. On leaving Israel, I put all my money in a brown envelope, which I took out of my suitcase to show to customs officers at London Heathrow Airport. Somehow, I failed to put the envelope back in the suitcase. At the train station in London, a man pointed out to me that something was dropping out of my pocket. It was the envelope with *all* the money I had in the world.

When my train arrived in Edinburgh and I checked into the hall of residence, the first book I came across in the library was George Orwell's, *Down and Out In Paris and London*. Barely a day in the United Kingdom, I knew exactly what Orwell meant, because I had already been there! The book had a chilling effect on me. Studying medicine at Edinburgh University was my dream come true and I enjoyed it, even though, WHO having failed to transfer my scholarship, I had to work while studying, in order to pay my way through medical school.

Psychiatry came late in my medical training. I was not really exposed to it until my fifth year in

medical school. My prime interests remained sociology, psychology, music and traveling. I got married before graduation, and in order to care for my young family, I went to work three months ahead of my classmates. I served my medical internship under Professor J. Dulthie and my surgical internship under Sir Michael Woodruff, the Australian surgeon who, together with James A Ross, performed the first successful kidney transplant in the UK. I was also fortunate to work with Dr. Dugald Gardner, the pathologist. Dr. Gardner arranged an internship in immunology and hematology for me at the New York University Medical School, in the summer of 1966. Being a young African physician who could speak Yiddish in heavily Jewish New York City had its social appeal and fascination. The next summer I spent working with Dr. Gardner in London, where he had become head of the Kennedy Institute of Rheumatology.

It was time to choose a specialty. I was interested in many areas --- neurosurgery, psychiatry, neurology, immunology and internal medicine, but I began to lean toward psychiatry.

The Chairman of Neurosurgery at Edinburgh offered me the position of Senior House Officer, but I declined. (My second son, Aubrey, is about to finish his residency in neurosurgery). I had a new baby (my first son, Anire, who himself has since become a plastic surgeon) and since internship in neurosurgery was particularly demanding, I did not want to combine that with raising a newborn. Instead, I took an offer as a Senior House Officer in Psychiatry at Guys Medical School Hospital in London. After one year, I began training in internal medicine.

Thereafter, for personal reasons, including the fact that many of my siblings were by now in the U.S. and I wanted to be near them, I moved to Brandeis University in Waltham, Massachusetts, on a National Institute of Mental Health fellowship, in a combined residency and social research program. There, I also earned a Doctorate of Philosophy in Social Welfare. I completed my residency in psychiatry at the University of Pennsylvania in Philadelphia, and then joined the faculty there as an Asst. Professor of Psychiatry.

From there I went on to Yale University as an Asst. Professor of Psychiatry, from 1984 to 1987, and

thereafter to Vanderbilt University School of Medicine. I became Clinical Professor of Psychiatry at Vanderbilt in 2003, and Professor of Psychiatry at Meharry Medical College, both in Nashville, Tennessee. In 2004 I accepted the position as Chairman of the Department of Psychiatry & Behavioral Sciences at Meharry. I also built a successful private practice, the Centre for Health, Culture and Society, for which I serve as the Executive Director. The Centre seeks to promote cross-cultural interrelationships through shared knowledge and experience, and serves to advance my work in psychiatry, and cultural psychiatry.

I enjoy membership in several professional organizations, including the American Psychiatric Association and the Society for the Study of Psychiatry and Culture. This affords me enormous opportunities to share knowledge, information and professional experience. I particularly treasure being designated a Distinguished Life Fellow of the APA.

Looking back on my background, my upbringing, where I have been, studied, and worked, my worldview and my dreams for the future, I realize that I am a sort of case study in cultural psychiatry myself. I have traveled to many parts of the world, and remain committed to, and fascinated by, the challenges and opportunities posed by the interrelationships between peoples and cultures under a singular umbrella of a common humanity.

My personal interests remain the continued well-being and success of my extended family, the search for solutions to the challenges that face humanity, in particular my fellow-Africans at home and abroad, including the African Diaspora, and how to contribute to making the world a slightly better place, by using my training and skills as a physician and a psychiatrist.

Professionally, I remain keenly interested in continuing work and research in the areas of culture and psychiatry, medicine and the humanities, and quality of life issues. In this regard, I plan in particular, to continue work in the areas of the elimination of health disparities, global psychiatry, and how to promote the relevance of cultural psychiatry in mitigating current and future global socio-political conflict

and crises, and post-conflict reconciliation and reconstruction.

In this last part, I will be providing a cultural psychiatrist's input to a subject already being addressed by my younger brother, Dr. Joseph Okpaku, Sr. from his vantage point as an expert in global strategic and political issues, governance, competitive development, and knowledge and information technology. The prospect of such family collaboration is exciting. We also plan to collaborate in addressing the challenge of HIV/AIDS, a subject in which both of us have published, again from the vantage point of two different perspectives.

I have had the opportunity to write and edit a number of books, including *Sex, Orgasm and Depression and Their Interrelationship in a Changing Society*, *Clinical Methods in Transcultural Psychiatry* (editor) and *Mental Health in Africa and America Today* (editor). I have lectured nationally and internationally, and published many professional and academic papers.

Above all, I maintain my keen interests in the arts and the humanities (my youngest son, Temisan, is an artist), and spend several hours each week playing the piano, as well as attending concerts and theater performances whenever possible.



Simon Dein M.D., Ph.D

I am an anthropologist and psychiatrist. I hold an academic post at University College London and am an Honorary Consultant Psychiatrist at Princess Alexandra Hospital in Essex.

I was born in the East End of London; within the sound of Bow Bells, so I suppose that makes me a real Cockney. Both my parents were born in England. My grandparents originated from Eastern Europe. My maternal grandmother came

to the UK from Poland in 1907 and my maternal grandfather came to the UK from Leningrad in 1912. My father worked as headwaiter at Blooms, reputedly the most famous kosher restaurant in the world (sadly now closed for serving non-kosher meat). My mother was a housewife. I have one brother, who is a barrister.

My early years were spent in Redbridge; an area in East London, which, twenty years ago, was predominantly occupied by lower middle class Jews, many of whom were taxi drivers. I attended a local grammar school, where Jews were in a minority and most of my fellow students were Christian. At school I experienced a lot of anti-Semitism.

I remember one day walking into school and someone saying; "Here comes the morning Jew".

There were a few other ethnic minority students at my primary school, and they were also discriminated against by other students. Words such as Paki were frequently banded about in the classroom. Bullying was rife. This was not just taunting; at times it amounted to frank physical violence. This experience had a significant impact on me. It sensitized me to the plight of other people who were discriminated against, and caused me to affiliate with minority groups in general.

My intention was originally to study pharmacy, but just before I finished secondary school, I decided instead to study medicine. I was accepted at the Middlesex Hospital Medical School and started there in 1977. Although I enjoyed the basic science and clinical curricula, I felt dissatisfied with the emphasis on science and the total neglect of arts and humanities.

In particular, since I was fourteen years old I had been interested in religion and philosophy, so while attending medical school, I decided to expand my education by going to evening classes on a wide range of subjects; including Marxism, philosophy and comparative religion.

I suppose I had always been keen to understand why so many people believed in God, without evidence for his (or her) existence. I had lost most of my extended family in Auschwitz, and could not understand why so many Jews persisted in their belief in a God who had not helped them

avoid the Holocaust that engulfed European Jewry during World War 2.

I qualified in medicine in 1983 and have worked as a doctor ever since then.

Following a brief period as a general practitioner, I trained as a registrar in psychiatry at Guys Hospital in London. There I was privileged to meet Dr Maurice Lipsedge, who had a profound influence on both my clinical and academic careers. He encouraged me to pursue a Master's degree in social anthropology, which I completed in 1991, and then go on to a PhD in social anthropology, which I completed in 1999.

While at Guys Hospital, I worked with many ethnic minority patients; mainly from African and Afro-Caribbean cultures, and this experience stimulated my interest in cultural psychiatry. During my psychiatric training I spent a few months in Madagascar, studying ritual and traditional healing. I also spent several months in the Philippines, studying psychic surgery.

Anthropology has taught me to question Western assumptions that are taken for granted in the scientific and in the popular world view of Western people, and to try to understand cultures as complex wholes, with each part mutually influencing the others.

Another formative influence on my academic career has been Professor Roland Littlewood. Apart from being a very close friend, we have published several papers together and co-edited one book. We share similar interests in culture, religion and psychiatry. We are currently working on a project examining 'the voice of God', and other projects looking at the phenomenology of religious experience. In addition, we co-direct a Master's degree program in Culture and Health, together with Dr Sushrut Jadhav, at University College London.

While religious practice has fascinated me for much of my life, I have struggled for many years with the possibility of becoming more religiously observant myself. However, I find Jewish ritual empty and unsatisfying. I remember, as a child, going to synagogue on the festivals and seeing people sitting praying, whereas at other times they would eat non-kosher food and go out on the Sabbath, thereby behaving like hypocrites.

In 1991, I went to live in Stamford Hill in North London, among a community of Hasidic Jews. I stayed until 1999. My motivations were various; I suppose I wanted to try out another, more religious, lifestyle. I decided that Orthodoxy was not for me and found it difficult to put up with the severe restrictions which I perceived it to impose upon me.

On another level, it was an academic quest to understand what makes people become so religious. I was living in the community when the spiritual leader, the Rebbe Menachem Schneerson, died. His followers believed that he was the Messiah. This gave me a unique opportunity to examine the response to failed prophecy in its evolution, and I have written extensively about this phenomenon.

Finally, I now work clinically as a consultant psychiatrist. However, my main clinical interests are in oncology and palliative medicine, and much of my work is with dying patients. This clinical work meshes with my academic interests in religion and spirituality, and how these areas enable people to cope with serious, often life-threatening illness, as well as with death and dying.

I am married to Kalpana, a consultant forensic psychiatrist. She is originally from Kerala, India. I have two children; sons age eight and two.

Stockholm in September; report of a planning visit, 16-22 June 2007

**Ronald Wintrob MD
Chair, WPA-TPS**

This was my first visit to Stockholm, and I was very impressed by the beauty and historic ambience of this city built on many islands and having a very strong link to the sea.



At the top of the hill in Sodermalm that overlooks the harbor and the historic central core of Stockholm called Gamla Stan, is the campus of Ersta University College, where our conference will be held Sep 9-12. The college specializes in the training of nurses and social workers. The campus includes a hospital, located across the street from the Ersta conference center and hotel. The conference opening ceremonies, the opening-day reception, and the morning plenary sessions and symposia will be held there. Lunches will be available for us at the conference center café and terrace. The afternoon symposia will be held just down the street, in the main campus administration building.

There is an obvious respect for maritime traditions; including the preservation and active use of ferries originally brought into use up to 100 years ago. They are numerous and are omnipresent features of water traffic around Stockholm. There are also super-sized ferries and passenger liners, taking thousands of travelers every day to Norway, Finland, Germany, Russia, Estonia, England, and to countries around the world. There are hundreds of boats in the many harbors all around Stockholm. Among them are many old and well-maintained sailboats and fishing boats. And there is the immense treasure of the *Wassa*, the Swedish warship and pride of the fleet that sank on her maiden voyage, heading out of Stockholm harbor in 1628. Recovered and restored over the past 25 years, *Wassa* is now on display in a superb museum in Stockholm harbor.

The accompanying photos will give you a graphic sense of how the history and life of Stockholm relate to the sea.

Sodermalm is the southern district of Stockholm. Located on a rocky hill with a commanding panoramic view of central Stockholm, across the harbor. The area has some of the oldest wooden houses in Stockholm; some of the few to survive the repeated fires that led to the banning of wooden buildings by the mid-nineteenth century.

Accompanying photos show the main buildings of the Ersta campus viewed from the harbor, and the entrance to the conference center and hotel campus, at sunset.



Sodermalm is an area of apartment buildings, shops, galleries, cafes and restaurants. I visited a number of them, and was much impressed with the variety and quality being offered.

The city hall of Stockholm is a monumental and iconic red brick building with an imposing square tower that has overlooked the harbor for 100 years now. You will certainly notice it as you drive into

Stockholm from the airport, then cross the bridge from Gamla Stan toward Sodermalm, continuing up the steep hill to the Ersta campus.

The Organizing Committee has been able to arrange an evening reception for conference participants at the Stockholm City Hall on Tue Sep 12



The two photos of the City Hall will give you the idea of its appearance and location.

The scientific program includes plenary presentations by Prof Jan-Hakan Hansson, rector and vice-chancellor of Ersta University College, Prof Jonas Alwall (Stockholm/Malmo), Prof Marianne Kastrup (Copenhagen) and Dr Riyadh Al-Baldawi (Stockholm). The WPA-TPS chairman's panel discussion will address the theme of inter-racial and inter-ethnic marriage. Panelists will be Ron Wintrob and Jim Boehnlein (USA), Marianne Kastrup (Denmark), Kamaldeep Bhui (UK), Hans Rohlof (The Netherlands) and Fumitaka Noda (Japan). Major symposia will be organized by WACP, SSPC and WPA-TPS.

There will be over 60 papers presented in the diverse symposia, as well as individual oral presentations and poster presentations by contributors from countries around the world.

In summary, there is a great deal to do and to see in Stockholm.

The conference program covers many topics of current interest in cultural psychiatry, and both the ambience and facilities being made available for our use during the conference at the Ersta University College campus are excellent.

Accordingly, I hope you will be with us in Stockholm in Sep and that you will be an active contributor to the conference program. I will be

looking forward to welcoming you to Stockholm, to Ersta and to this conference being jointly sponsored with SSPC, WACP and WPA-TPS.

ConferenceURL:

<http://www.esh.se/en/conferences-and-seminars/international-conferen>

