

**Editor: Fumitaka Noda (Japan)**  
**Associate Editor: Mario Incayawar (Quichua-Inca)**

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## Report on the Stockholm Conference; 9-12 Sep 2007

It was a blustery autumn weekend when nearly one hundred conference participants arrived in Stockholm from North America, Europe and Asia to attend the conference on 'Multicultural

Dialogue in a Globalizing World,' jointly sponsored by WPA-TPS, SSPC and WACP, that convened Sep 9th through Sep 12th.



The venue for the conference was the dramatically located campus setting of Ersta College, in the southern Stockholm community of Södermalm. Ersta's campus is perched at the crest of a steep hill above the entrance to the inner harbor of Stockholm and offers spectacular views of the city center; a twenty-minute walk down the hill and across the bridge.

The conference welcoming Sun afternoon Sep 9th was followed by the keynote presentation by the rector of Ersta Sköndal University College, Prof Jan-Hakan Hansson, titled "Reflections on Challenges for the Swedish Welfare State in the New Millennium:



Examples from current issues in psychiatric care in Sweden". That was followed Sun evening by a reception for all conference

participants at the Ersta Conference Center, hosted by Prof Hansson and Ersta College.

After formal opening ceremonies on Mon morning, the scientific program continued with a comprehensive



overview plenary presentation by Marianne Kastrup from Copenhagen, on “Issues in Cultural Psychiatry in the Scandinavian Countries”. Dr Kastrup cited and summarized contributions to research and clinical care in cultural psychiatry since 2000 by numerous Scandinavian academics and clinicians, as well as pointing out the implications of those contributions for policy related to health care and social services. Dr Kastrup’s presentation fit very well with that of Prof Hansson, addressing similar philosophical and policy issues from clinical and research perspectives in cultural psychiatry.

The first morning of the conference included two plenary symposia; one on inter-racial and inter-ethnic marriage sponsored by WPA-TPS, and another on worldwide development of cultural psychiatry,



sponsored by WACP. These were the first of nearly thirty symposia that were incorporated in the program over the three days of the conference. The symposium topics ranged from cultural issues in the development of DSM-V to biculturalism and multiculturalism in the life experience of cultural psychiatrists, from gender and cultural variables in psychiatric assessment to medical illness among refugees. Other symposia addressed comparative transcultural therapies in European

countries, mental health issues in northern European countries, explanatory models and narrative in cultural psychiatry, chronic stress and mental health issues related to migration, doing cultural psychiatry research on a small scale, psychiatric assessment of refugees and immigrants, coping abilities of migrant mental health professionals, culture-related case histories, medical anthropology and mental health service provision, cross-cultural perspectives on anxiety disorders, culture and religion, and culture and psychotic disorders.

Over the three-day course of the conference there were nearly 100 papers presented, as well as 13 posters of scholarly work in cultural psychiatry. A complete list of papers and posters presented at the conference can be accessed on the conference website.



On the final afternoon of the conference, Drs Wintrob, Boehnlein and Tseng reported on the current activities and future plans of WPA-TPS, SSPC and WACP respectively.

The social program was as varied and intense as the scientific program, leaving only one evening free for conference participants to explore some of the fine restaurants and cultural life of the Swedish capital. Among the highlights of the social program were a reception, buffet dinner and guided tour at the extraordinarily imposing Stockholm City Hall, hosted by the Stockholm District Council, and a wonderful closing gala dinner at the Skansen national museum site.

Following the conference, many participants took advantage of the opportunity provided by being in Stockholm, to spend a few more days exploring the city, other regions of Sweden and other Scandinavian countries.

It was, overall, a very successful conference, leaving participants with the feeling that they were glad to have been able to be in Stockholm for a unique and fulfilling experience of psychiatry and culture with a Swedish flair and a Scandinavian freshness.



The conference sponsoring organizations are especially grateful to Dr Riyadh Al-Baldawi, the psychiatrist chairman of the Stockholm Organizing Committee, for selecting the Ersta Conference Center as the conference venue and for coordinating the overall planning for the conference, along with Prof Hansson and Prof Jonas Alwall. On behalf of all conference participants, we want to thank them for their contributions to the conference. We also want to thank the Ersta College administrative staff, led by Ann-Margret Bergman, whose kindness and generous help were invaluable, both leading up to and throughout the conference.



Ronald Wintrob, M.D.  
Chair, WPA-TPS

Jim Boehnlein, M.D.  
President, SSPC

## 1st International Conference of Transcultural Psychiatry in the German-speaking Countries; On similarities and differences Witten, Germany 6-9 Sep 2007

### **The Doctor – Foreign Patient Relationship; a Transcultural Challenge**

*"... owing his physical and mental predisposition to genetics, man gains his real inner life only through tradition which is brought onto him by the environment of human society... Our learning, accepting and imitating, our upbringing and our milieu make us spiritually a human being after all..."*  
( Karl Jaspers 1913)

The phenomenon of migration is as old as humankind. The world we live in has always been a world of fusion – a melting pot of peoples. People began leaving their homes for better living conditions and more safety very early on. With the beginning of the 19th century this journey experienced a change through a new kind of mobility. The political, technical and most of all the development of the media brought people closer together yet confronted us with the fact how distant we are from each other at the same time.

“Migration ist nicht nur Wechsel von einem Ort zum anderen, sondern gerade auch Wechsel zwischen Kulturen, von einer Gesellschaft zur anderen und von einem Gesundheitssystem in ein anderes.” [1]  
[Migration not only means moving from one place to another, but also moving between cultures, from one society to the other and from one health system to another one.]



From left to right Drs. Bernhard Kuechenhoff (Switzerland), Solmaz Golsabahi and Eva van Keuk (Germany) and Alexander Friedmann (Austria).

The power imbalance that can be observed in every relationship also exists in hospitals. Migrants usually are the less powerful partners in this relationship and accordingly experience greater stress and more painful internal conflict. Medical personnel are perceived and experienced as the more powerful participants in this relationship. “How does it feel when I use language, or more precisely: what happens to me when I speak?”

Expression of ideas and the terminology for their description, as well as the expression of emotions are different in different languages, and in some cases no corresponding translation exists. One language is more direct and supposedly more open, while another is more reserved and indirect expressing “the meaning” in a completely different way.

In spite of these obstacles or perhaps because of them, some ideas and emotions may be clearer and more intense when they are expressing in another language.[5] “To travel is the best way to learn and to make yourself stronger.”

In her book *Harem Yasmina*, the grandmother, told her granddaughter, F. Mernissi, a well-known professor in Morocco: “You have to focus on the strangers you meet and try to understand them. The better you understand a stranger –

and through him yourself, the stronger you are going to be”. [2]

“In order to learn from traveling, you have to practice receiving messages...The most important thing strangers carry with them is their strangeness. If you can focus on differences and things unlike anything you know, you may notice that tiny spark.” [2]

More and more often hotel owners are forced to carry out extensive repairs because western bathroom floors get broken or tiles loosened: X or Y people act “like pigs“ in bathrooms, as angry hotel owners sometimes like to put it. Precisely the same choice of words could be used by X or Y people when commenting on foreign visitors not following local customs.

Behavior, emotions and evaluations are closely connected to cultural context. Contact with other cultures makes us curious, and stimulates us to direct our attention toward our own culturally shaped beliefs and behaviors. Things we normally take for granted can be seen in a new light and are then judged differently. Questioning and exploring them helps to understand them better and makes them more transparent for the outsider.

This is the natural development of cultural-historical processes and structures. On our journey to the genesis of cultural-historical processes, reasons to affirm rational explanations for diversity can be found, as well as reasons which let us see what we have in common:

Psychological disorders and illnesses in general have existed at all times and in all cultures, as we know from oral tradition and from written records that tell of dramatic events and reactions to personal tragedies.

When facing death, Gilgamesh, ruler of Uruk, was moved by melancholy. Nizami's poem *Leila and Majnun*, tells the story of Majnun, a man who is obsessed

with his love for Leila. Majnun means literally “possessed by demons” and in this particular poem refers to a man who has lost his mind through love.

The contradictory, simultaneous development of globalization and regionalization makes contacts, confrontations and attempts at dialogues with non-western cultures more frequent and more intense, and more diverse at the same time. (Gingrich 1999) [6]

"If we were successful in getting to know these foreign societies better, we would create an opportunity to detach ourselves from our own society, not because our society is so bad or because it is the only bad one, but because it is the only society we have to emancipate ourselves from." Claude Lèvi- Strauss.

People are different. These differences can be of great depth or only superficial. They can originate from different aspects of everyday life like gender, religion, education, politics, physical environment and many other factors. Their influence is even greater, and affects the doctor-patient relationship more thoroughly, when patients are foreigners. Therefore, the dialogue between patients and medical professionals has to go beyond the focus on health and illness. Creating awareness of historical roots, as well as of the current changes in political and economic circumstances that influence the way patients perceive and understand their illnesses, are of great relevance.

The meaning of transcultural psychiatry, as it was defined by Wittkower in 1972, should become a leitmotif for physicians if they want to master the challenges of contemporary globalization. Wittkower's definition is as valid today as it was then: “Transcultural psychiatry is the branch of psychiatry which deals with cultural aspects of etiology, frequency and types of mental illnesses, as well as with their treatment and

follow-up within a defined unit. The term “transcultural psychiatry“, which is an extension of cultural psychiatry, means that the scientific observer looks beyond the limits of one cultural unit and includes other cultural areas”. [4]

The knowledge of transcultural concepts in medicine is going to be of great influence on the quality of medical care.

The practical relevance of everyday health care in host societies for immigrants should be most important and not the fascination of observing people from distant countries as examples of ‘the exotic’. Therefore, the integration of transcultural subject matter into the medical curricula of universities, as well as making training opportunities readily available in this area should be the standard in every-day medical care, and not the exception.

It is not acceptable any more to focus just on the proof of general theoretical psychiatric categories, or to direct attention from the “centres to the periphery“. The focus should be on mutual acceptance and an understanding of one's own respective reference systems and context of meaning. [7]

The aim of this 1st International Conference on Transcultural Psychiatry in the German-speaking World is to address many of the topics inherent in this rapidly evolving field and to consider future perspectives for research and clinical service.

The scientific development of transcultural psychiatry and psychosomatics, as well as the changing general conditions of health politics affected by globalization and its influences on further training and education were addressed during the conference.

The 1st International Conference on Transcultural Psychiatry in the German-speaking World attracted the participation of a large number of psychiatrists, psychologists, social scientists, nursing and

social work personnel, educators, administrators and students. More than 230 people registered for the conference; 150 from Germany, 50 from Austria, and 30 from Switzerland.

The conference program was comprised of 31 symposia, covering all areas of transcultural psychiatry, including:

- two symposia on the future of transcultural psychiatry
- two symposia on culture and psychotherapy
- two symposia on transcultural psychiatry within the forensic context
- two symposia on transcultural psychosomatics
- three symposia on diagnostic issues in transcultural settings
- five symposia on culture and psychotherapy
- refugee topics and challenges for transcultural psychiatry
- the ethnopsychiatric intervention group at the psychiatric University Hospital Zurich
- psychotherapeutic starting points for survivors of organized violence
- a holistic point of view from the beliefs of the peoples of the Andes mountains of Latin America: "Susto and the meaning of illness"
- PTSD and transcultural Psychiatry
- psychotherapy with survivors of torture and civil war
- group psychotherapy with traumatized refugees
- resources, stabilization and treatment of traumatized migrants
- linguistic and sociocultural mediation in psychiatry
- the concept of body and soul in African culture and consequences for the treatment of African patients in transcultural psychiatry
- politics, society, emigration and transcultural psychiatry – Migration

politics in the German speaking world

- culture, religion, society and psychiatry
- linguistic and cultural mediators in psychotherapy

Members of the Program Committee for the Witten conference included:

- Karl H. Beine, Solmaz Golsabahi, Eva van Keuk, H.W. Gierlichs, L. Joksimovic and Sebastian von Peter (Germany )
- Alexander Friedmann and Max. H. Friedrich (Austria)
- Bernhard Küchenhoff (Switzerland)
- Ron Wintrob (USA)

Quotations:

[1] Salman R.: In Czycholl D.: Sucht und Migration“, 1998, S. 33

[2] Pöchlner, Franz: „ Kulturelle und sprachliche Verständigung mit Nichtdeutschsprachigen in Gesundheitseinrichtungen“. In. Mathias David et al.: „Migration, Frauen, Gesundheit“, Mabuse Verlag GmbH, Frankfurt am Main, 2000, S. 155-177

[3] Golsabahi, S., Friedrich, Max.H.; : „ Spital-Ort der Begegnung“- Arzt- [fremder] Patient- Beziehung, dem Mutter-Kind-Pass gleichwertig, Universität Wien, 2003

[4] Wittkower, E.D.: Probleme, Aufgaben und Ergebnisse der transkulturellen Psychiatrie“. In: Ehrhardt H.E. (Hrsg): Perspektiven der heutigen Psychiatrie, Frankfurt/Main, 1972, 305-512

[5] Georges-Arthur Goldschmidt: „ Als Freud das Meer sah“, Fischer Verlag, Frankfurt am Main, 1999, S. 13.

[6] Wolfahrt, Zaumseil: „ Transkulturelle Psychiatrie-Interkulturelle Psychotherapie“, Springer Verlag, Heidelberg, 2000, S. XV

[7] Wolfahrt, Zaumseil: „ Transkulturelle Psychiatrie-Interkulturelle Psychotherapie“, Springer Verlag, Heidelberg, 2000, S. XV ff

[8] R. van Quekelberghe: „ klinische Ethnopsychologie“, Roland Asanger Verlag Heidelberg, 1991, S. 11 ff

## Recommended literature

- Curare; current and past issues
- Transcultural Psychiatry; current and past issues
- Domening, Dagmar: Professionelle transkulturelle Pflege, Hans-Huber-Verlag, 2001
- David, Mathias: „ Migration und Gesundheit, Mabuse- Verlag, Frankfurt/Main, 2000
- Pfeiffer: Transkulturelle Psychiatrie, Thieme-Verlag, Stuttgart, 1994
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- Wen-Shing Tseng; Handbook of Cultural Psychiatry. Academic Press, San Diego, 2001.

## Biosketches



**Prof. Mohamed Fakh El-Islam**  
*Academic Consultant*

I was born in the north of Egypt in 1935 as the third child in a sibship of eight. After basic general education in schools in the south of Egypt and in Cairo, I attended the medical school of Cairo University. Upon obtaining my bachelor degree in medicine, I spent two years of training in surgery and medicine and specialized in neurology. I obtained a scholarship to study and train in psychiatric medicine at the Institute of Psychiatry in London, and obtained the diploma in psychological medicine (DPM), and Membership of the Royal College of Physicians (MRCP) in Edinburgh, with psychiatry as my selected subject. Then, I trained in individual psychoanalytic and group therapies for two years at the Tavistock Institute of Human Relations in London.

Upon my return to Egypt, I worked as a lecturer at Cairo University medical school, where I continued until I became an associate professor. Upon inception of the British Royal College of Psychiatrists, I became a foundation member and was later elected as a fellow of the college.

My interest in cultural psychiatry developed when I was able to make informed comparisons between clinical psychiatric

practice in U.K. and in Egypt, where I studied differences in Moslem and Christian Egyptians who had depressive guilt. This was my link to the Wittkower-Murphy transcultural group at McGill University in Montreal, Canada.

Upon moving to Qatar in 1971, the first ever psychiatric service was established in Doha. This was a great opportunity for me to study cultural aspects of psychiatry in this small nation, which was a traditional affluent society. I launched studies on cultural aspects of depression and schizophrenia and on intergenerational conflict, and published the results of these studies in international journals.

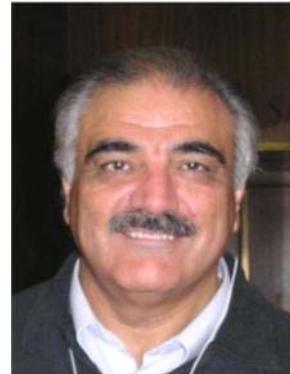
A chronic culture-bound somatization syndrome was found in Qatari women, who did not have children in a community which approved marriage and mothering as the only acceptable role of women. The family role in rehabilitation of patients with schizophrenia was compared to its Western counterpart in relation to expressed emotions.

In 1980 I established the first academic Department of Psychiatry at the University Medical School in Kuwait, another traditional affluent oil-exporting country. As professor and chairman I conducted and supervised cultural psychiatric research, including clinical and community studies of intergenerational conflict and illness behavior. As WHO adviser on mental health, I conducted a field trial of ICD-10 criteria for diagnosis of schizophrenia, to ascertain their transcultural generalizability prior to the inception of ICD-10.

In 1990 I returned to Qatar after the Iraqi invasion of Kuwait, to find the eclipse of the culture bound syndrome I described in the 1970's. As women acquired more complex societal roles outside the family, and doctors' diagnostic psychiatric orientation improved with in-service

training, early diagnosis and rehabilitation prevented the development and chronicity of the syndrome. I studied the pathoplastic effects of culture on phobic disorder in Qatari women, and was able to explain the rarity of agoraphobia among them. In 1996-1997 a brief spell in U.K. helped to compare clinical practice then to earlier practice in the 1960s, with variation in the medical culture and in patients' expectations.

Since my final return to Egypt, I have been mainly interested in the training of young doctors in clinical psychiatry in both state and private psychiatric hospital practice. My most recent cultural research included a 22-year follow up of religious psychiatric symptoms and the transcultural use of Schneiderian 'first rank' symptoms in the diagnosis of schizophrenia.



***Riyadh Al-Baldawi, M.D., Ph.D.***

*Director*

*Orient Medical and Rehabilitation  
Centre*

*Stockholm, Sweden*

### **My pathway to cultural Psychiatry**

Life includes a lot of memories. The memories are a part of us and it is not always easy to share them publicly. Some of them include happiness and others sadness, but altogether they form our life. When one of my mentors and friends, Ron Wintrob,

asked me to share some of my memories, I thought they could be of interest to my colleagues in the field of cultural psychiatry and for those who intend to start a career within this field. I thought this task would be easy. But when I started the process of putting my memories on paper I discovered how difficult it is to write about oneself. I hope these memories will at least outline some of the reasons that made me find my way into this field. I have changed some of the details out of respect for some of the people I refer to in this essay who I am unable to contact to ask permission.

### **My home and family background**

I was born in Baghdad, the capital city of Iraq. My family lived in a house in the heart of the old part of the city. My father worked as a senior administrator at the Iraqi ministry of justice for many years (I think more than 35 years). His profession gave him a high social position and respect not just from our extended family members and friends, but more generally in Baghdad. My parents were cousins. Following the traditions of that time, they got married when my father was 26 years old and my mother was just 14 years old. She gave birth to her first child at the age of 15. My mother's formal education was limited, as was generally true with the majority of women in Iraq in the early decades of the 20th century. She attended a religious school where she was taught to recite the Quran, but not how to write. She was a housewife throughout her life.

I was the fifth of six children in our family. Me and my brother one year younger than me, were the youngest children in the family. There is an age difference of over 17 years between us and the older children. All the members of our extended family were very surprised when my mother became pregnant after 16 years.

By the time I was born, my oldest brother had already finished his university education as a pharmacist, had started to work and was

on his way to the USA to begin his PhD studies. He was diagnosed with cancer and passed away at the age of 27. This tragedy had a profound impact on my family, and particularly affected my mother throughout her life. My two sisters were well educated as well; one of them was a lawyer and the other one a teacher. My father was one of few Iraqi young people of his generation who got an education in English. An English school was opened in Iraq after the occupation by the English army, following the First World War. He led his life with respect towards English traditions such as tea time in the afternoons. Discipline and loyalty towards his job were very important to him. He was one of very few Iraqis who changed his clothes from the traditional Iraqi style to the English way of dressing. He was very liberal as a Muslim and enjoyed a good whisky, but preferred the traditional oriental drink (Araaq). Therefore, there was a big contrast in our home between my father's way of living and my mother's.

My mother was a very religious woman, but not conservative or intolerant. She tried to follow the traditional Islamic way of living but at the same time accepted her husband as he was and gave love and encouragement to all of us. Furthermore, she gave all her children the opportunity to develop their own way of living and accepted their decisions about following Islamic rules. She had a great impact on all of us and earned our respect and admiration.. She was the one who kept the family functional through her kindness and caring. She was very wise and understanding, which made her an important person not just for our nuclear family, but for all our relatives and friends as well.

When I was four years old my family moved from the old part of Baghdad to a new area in the suburbs of the city where many middle class families had built modern houses in the American or English style. The most interesting aspect of this new residential suburb of Baghdad was its multi-ethnic and multi- religious composition.

Muslims, Christians and families with a Jewish background as well as Arab, Kurd, Turkmen and Mandai all lived in this area. Many embassies and their staff moved there as well. Consequently, I grew up in an atmosphere of multicultural tolerance and developed friendships with people regardless of their background. On our street, where thirty families lived, while the majority were Muslims from both Shia and Sunni background. There were also several Christian families and five Jewish families. Growing up, this was a very good environment to teach us how to live and develop tolerance and respect for each other. It enabled us children build friendships with each other regardless of our religions or ethnic backgrounds. In fact, we didn't have any idea about these differences. All the families on our street belonged to the middle class and most of the fathers were highly educated and worked for the government or had other high status jobs... We went to the same school and played football on the same teams. We celebrated each other's birthdays and enjoyed swimming together in the Tigris river, close to our houses.

### **My first cross-cultural experience**

One of my friends who lived in the same street and went to the same school was Dawood. We were the same age. Dawood was one of the cleverest boys at our school, especially in mathematics. I was very interested in football and played, at that time, on our school's top team. One day Dawood asked me to teach him how to play football and I invited him to watch one of our games. We agreed that I would teach him how to play football and in return he would help me with mathematics. We became very close friends. He would visit and spend time together at each others' home. He was very fond of my mother's cooking and I enjoyed his mother's tasty cookies.

After the 'six day war' between the Arab countries and Israel, Dawood told me that he

and his family had to leave Iraq. I was very surprised and upset by this news. I asked him why, and where they would go. He told me that it had become difficult for them to stay in Iraq as a Jewish family after this war. His family had lived in Iraq for many generations and his father didn't want to leave but was forced to. He told me that he was leaving for their original home Israel. When I asked him if Iraq wasn't his home he started to cry and so did I. He just looked at me and said: I don't know who I am.

Dawood and his family left Iraq within two weeks. My whole family was very sad about their leaving Iraq. My mother liked Dawood just as much as I did, and when he came to say goodbye she didn't know what she could give him as a memory. She found a small Quran and she asked him to take this with him as she usually did when somebody decided to travel far away. She told him that she knew that he was Jewish but that she was sure that the Quran would keep him safe, In sha Allah (If it was God's will). He took the Quran, thanked her and asked her to remember him. We never forgot about Dawood and his family and the memories have stayed with us. I haven't had contact with him since the day he left. This was my first experience of painful separations and the meaning of cultural identity.

### **My migration to Europe and my pathway to becoming a cultural psychiatrist**

When I finished school I wanted to study medicine, which had been my dream since I was child. I was given the chance to pursue my studies in the former Soviet Union, as an exchange student. In the beginning of the 1970s, the Soviet government invited students from a number of developing countries to study there on exchange programmes.

This was an opportunity for me to escape the expected way of living and the political turmoil in Iraq which had started at the time of the Baath regime takeover of power in

Iraq. I wanted to move outside Iraq to be able to discover new cultures and traditions. My father, who had the dream for me and my younger brother to study in the west (and preferably in England, which he considered to be the ideal place for education), was not happy at all when I informed him about the opportunity I had to study in Moscow. He became very sad, but realized that this opportunity for me to study in Moscow would be a first step to expanding my life prospects.

The years I spent in Moscow were very enjoyable for me. Even though the people, were poor they were very hospitable. Life was sometimes very difficult in Moscow due to the rigid political system and controlling. However, as exchange students our lives were less subject to political control, and we were allowed to travel outside the Soviet Union, whereas most Russian people weren't. This atmosphere taught us to be very diplomatic and find different ways to cope with the rigidity of the Soviet system. Campus life in Moscow at that time was characterized by a highly international atmosphere, with a lot of students from different cultural and ethnic backgrounds. Studying in such a rich and complex atmosphere greatly influenced my way of thinking.

My father passed away during the second year of my studies in Moscow. I was very sad that he hadn't been able to see me graduate as a doctor, which was his life's dream. And I could not go back to Iraq at that time because of the tense political situation. There was substantial risk that they could stop me from coming back to the Soviet Union to finish my studies. So I asked my brother to bring my mother to Moscow. After five years by myself in Moscow, it was a wonderful reunion with my mother and brother. This was her first trip to Europe.

Moscow, with its more than thirty theatres and concert halls, opened my eyes to the

world of classical music. You could attend an opera or a ballet performance almost every day. The city's many museums, with paintings from some of the most famous artists in the world, from different eastern and western schools of art, also gave me an opportunity to learn about art.

All this formed me into the person I am today and altered my view of life. I embraced new experiences from other cultures and mixed them with Arabic traditions and beliefs. This approach made me think about the world differently and provided me with a wider perspective on cultural identity. My new identity brought with it more respect and tolerance towards others, regardless their cultural, ethnic or religious background.

After completing my medical degree in Moscow, I went to England to pursue fellowship training for the Royal College of Surgery. I lived in London and started to take a special course in English. I had started working at a hospital in London when war broke out between Iraq and Iran in 1980. The regime in Iraq asked all Iraqi medical doctors to return to the country and participate in the war effort. I, and many others, refused and return, or participate in the war. The regime punished us by refusing to renew our passports.

The British government, as well as many other governments in the west, supported Saddam Hussein's regime and insisted that all Iraqi students without valid passports leave the country. This was a tragic part of my life. I was very sad and alone, my family couldn't send me any financial support because of the war and I couldn't find a job in England or continue my studies without support. This was a difficult time for me and formed my future interest in migration and acculturative stress among migrants.

I was in such a dilemma about how I could continue my medical studies and career that I finally decided to call my department head

at the University in Moscow. I started to explain the situation I found myself in and before I had had the time to finish, he asked me a question which I found rather strange initially. He said; "Riyadh, aren't you still our PhD student at the department"? I didn't understand what he was getting at, so I replied; "What do you mean"? He reiterated his question and told me not to worry. By the next week, I was given a visa that enabled me to return to Moscow and continue my studies as a PhD student. I finished my PhD studies in 1985.

What I learned from this experience is that the world is full of kind people and what we have to learn to do is to help others as much as we can in their times of crisis.

### **My recent life in Sweden**

I came to Sweden at the beginning of 1986 as an asylum seeker. I found a country that gave me security and stability. I built my family and have seen my children grow up here. Since 1991, I have had Swedish citizenship, which I am proud of. I am trying to integrate the culture I was raised in with the new and different ones that I have experienced during 35 years of immigration.

I still have the dream that Iraq will one day become stable and secure enough that I can take my children back to visit Baghdad and show them where I lived and grew up, and maybe we can swim together in the Tigris.

I have tried to help people in need ever since I came to Sweden. I have been involved in developing transcultural psychiatric service models within the public health and social services, as well as in the school system. I hope that make it easier for these systems to understand immigrants' traditional cultural and religious backgrounds, which will positively affect the services provided for those who need help and support. My involvement in this subject has given me an opportunity to bridge differences and make it possible for the immigrants to understand

the indigenous Swedes and their way of thinking, which will help them in their adaptation process to a new culture and social system. I have tried, and am still trying, to understand and help people in crises and especially those who have been forced to leave their home countries. I am increasingly interested in the migration process and its effects on individuals and families.

I changed my specialty from surgery to psychiatry mainly because I find that psychiatry could help me to work very closely with those people who experience deep crises and particularly with immigrants. My mother passed away here in Sweden six years ago and is buried here in Stockholm. She wanted to be buried in Iraq close to her son and husband. However, the situation didn't allow it. After we finished the ceremony of burying my mother I told my children and other family members that from this day on we put our roots deep in this land.

I find now that we are more world citizens than citizens of one country. We need places to relate to, but we need to remember that the world with its people is our true home. Friendship and sympathy don't belong to a certain place but can be found all over the world.

This has influenced my choice of cultural psychiatry as a part of my professional identity. I have found humanity, tolerance and the acceptance of others with extensive professional and research competence as the most important part of this clinical subject.

The world is changing every day; the globalization process has made people closer to each other. However, at the same time the world is increasingly characterised by more serious confrontations and conflicts related to religious and ethnic differences. That is why we are in great need of cross-cultural perspectives in our work as clinicians and researchers. Cultural

psychiatrists could play an important role in the future organization of the world based on understanding and acceptance of others, with tolerance for their differences.

### **Professional Activities in Cultural Psychiatry in Sweden**

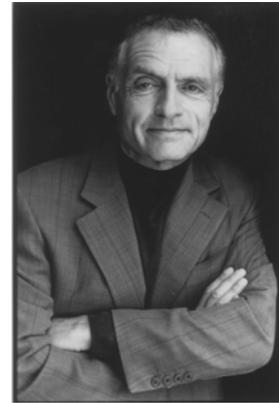
I became a consultant psychiatrist in 1994. In 1990, I inaugurated the first Swedish immigrant organization against drug abuse, and in 1995 initiated the first intercultural and multiethnic clinical centre in Stockholm for clinical evaluation and rehabilitation of individuals and families from different ethnic and cultural backgrounds. It was named the Orient Medical and Rehabilitation Centre. I have been the director of the Centre since 2003.

In 1999, I helped inaugurate and became the first director of the Transcultural Centre in the Stockholm region, under the auspices of the regional government. It is an education and consultation centre for medical staff who work in the public health service in Stockholm.

I have offered intensive education programs and clinical consultation for medical and social service personnel throughout Sweden who provide health, mental health and social services for immigrants and refugees. I collaborate with staff of several Swedish universities and colleges on similar courses related to immigrant and refugee issues.

I am continuing my research on migration, acculturative stress and adaptation among immigrants to Sweden.

In 2005, I helped inaugurate and have been a member of the executive committee of the International Iraqi Medical Association. The Association is dedicated to enhancing contact, communication and collaboration between Iraqi doctors within and outside Iraq.



***Morton (Morley) Beiser, M.D.***

According to Garrison Keilor, all the children in Lake Woebegone are above average. Regina, Saskatchewan, the less than amazing prairie city of 65,000 where I grew up, outdid Lake Woebegone. In Regina, everybody was better than everyone else. The Catholics were better than the Protestants and both were better than the Jews. The Russians and the Ukrainians looked down on the Germans their countries were fighting, and finally beating, in World War II. A British accent was an automatic claim to exceptionality. Nobody thought much about the three or four Chinese families who ran the town's hand laundries. One thing everybody agreed about: if you went into the Aboriginal part of town, you deserved whatever trouble was sure to come your way. I don't know what went on inside the other communities that were the most picked on, but Jewish parents like mine always reassured their children that we were the best: we were, after all, God's chosen people. No doubt the Chinese immigrant families and the Aboriginals sharing the bottom rungs of the town's social ladder with us told their children similar things.

Aside from being ugly, there was, it seemed to me, something absurd about racial discrimination. Years later, when I became more reflective, I looked back on those early years with sadness. Those mutual hatreds robbed everyone. Life could have been so

much better if we had all been allowed to be proud of who we were, and encouraged to share our cultures, rather than fight about them.

Medicine attracted me during my undergraduate years at the University of British Columbia, partly because it seemed a way to do some good in the world, partly because it was a secure way to make a living. To tell the truth, too much of the learning was rote, too much of the teaching authoritarian. A brilliant, charismatic and provocative professor of psychiatry relieved the boredom. He offered me summer jobs with his research team, and, the more I got to know about the field, the more I liked it.

It would take too much detail to explain why I ended up doing a residency in psychiatry at Duke University in Durham, North Carolina, rather than going to New York as I had always thought I would. I'm glad I did go there because the 1960's were exceptional times in the old South.

My residency began in July of 1961. I drove to North Carolina in the first car I ever owned. Having characteristically over-estimated what I could accomplish, I had decided to drive non-stop from New York City to Durham. By the time I got to West Virginia around 11 o'clock on a dark, rainy night, it was clear that I had made a mistake. I started looking for a motel, but they all had No Vacancy signs. Finally, though, I saw one that had vacancies. I pulled up, walked to the front desk and asked to register. The man at the desk seemed a bit hostile and more than a bit suspicious. He said to me, "You can't stay here." I said, "Why not? Don't you have rooms?" "Sure we do, but not for you. Did you see what the sign out front said?" I had noticed a sign that didn't make a lot of sense. It said "Colored." It was late, I was dazed and exhausted and I was a naïve Canadian. I had thought maybe they were advertising that they had color TV. The light finally came on. I said, "You mean I can't stay here because I'm white?" "That's

right son," was the final word. I ended up sleeping in my car.

Those were tumultuous years. They were the years of sit-ins and freedom rides, of Ku Klux Klan murders, and, finally, of desegregation. Duke University Hospital, which used to have washrooms labeled "men," "women," and "colored," painted over the word "colored," and substituted "staff." To considerable fanfare, Duke University admitted its first black medical student. Far more quietly, they decreed that he was not to examine white patients: he had to do his clinical work at the black-only hospitals.

It seems hard to imagine today, but, in the 1960's, most chairs of psychiatry in the United States were occupied by psychoanalysts. Everything that used to be called neurosis could be explained as some variation of an unresolved oedipal conflict. If the patient was well enough educated, he or she could be treated with psychoanalysis or psychoanalytically oriented psychotherapy.

Outside the Department of Psychiatry, the civil rights movement was changing the way people thought about themselves and about each other, sociologists and politicians were talking about the brutalizing effects of poverty and blocked ambition, and psychiatrists like Franz Fanon were writing about the psychological legacy of apartheid and colonialism. Inside, nevertheless, everything went on as before. Unhappiness was a product of frustrated internal drives, civil rights leaders were all rebelling against their fathers, poverty was not a cause, but a product of mental weakness, and people like Fanon were psychologically disturbed radicals.

There were oases that offered intellectual refreshment. One of these oases was a brilliant Chinese analyst named Bingham Dai. Because he wrote so little, Bingham is not nearly as well known as he should be.

The problem is that he was too much of a perfectionist: he once told me that he was irritated by an editor who was rushing him to finish a manuscript. I asked him how long he had been working on the paper. He admitted that it had been seven years.

Born in China, Bingham received a PhD in Sociology from the University of Chicago where he had been trained as a psychoanalyst. At Duke, he offered the first year residents a seminar in dream interpretation. At our first session, Bingham told us about a dream presented to him by a patient and asked us to analyze it. The night before her only daughter was to be married, Bingham's patient dreamed she was wandering about the city picking up pieces of coal. What did that mean? We were all sure we knew. Some of us opined that she was depressed about being abandoned, symbolized by the blackness of the coal. Others felt she was jealous of her daughter's happiness, and wanted to blacken her with coal. Bingham listened to all this wisdom and then asked: "Do you think it might have been important to ask me where I saw this patient?" Well...yes, we all agreed that might have been important. So Bingham told us that it had been in Taiwan. We all nodded sagely. "Why is that important?" he then asked us. We didn't know. "In parts of China, coal is a symbol of good luck."

One day, Bingham suggested that I read Alexander Leighton's new book, *My Name is Legion*. By now, I knew how valuable it would be to follow his advice.

The book was a brilliant synthesis of how development, the internal life and the external environment interact to frustrate, or to promote human happiness. I was so impressed that I flew to New York City, walked into Leighton's office at Cornell medical school and asked him if I could become his research fellow. I think that my chutzpah amused this rather reserved gentleman. He agreed to take me on and later, when he assumed a chair of Behavioral

Sciences at the Harvard School of Public Health, he invited me to join him as an Assistant Professor. For the next ten years, I worked with Alec on his famous Stirling County Study, one of the first psychiatric epidemiology surveys to be undertaken and one of the first to reveal the hitherto unsuspected burden of mental disorder in communities. My major responsibility was to supervise a sub-study of a panel comprised of 60 people with psychiatric disorder and 60 who seemed to be successful and happy. Some of my earliest publications, which come from this period of work, deal with defining and trying to measure successful adaptation.

Alec was also one of the pioneers of cultural psychiatry, bringing his rigorous research methods to Nigeria where he worked with people like Adoye Lambo to produce the well-known work, *Psychiatric Disorder among the Yoruba*. Alec generously supported my own ambitions by introducing me to the famous researcher, theoretician and innovator, Henri Collomb. Alec also permitted me time away from Boston during which I helped Henri design and carry out a study of psychiatric disorder among the Serer of Senegal, West Africa, and about the effects of migration from rural villages to the city.

An award from the Macy Foundation made it possible for me to spend a sabbatical year in France and Senegal completing the study and writing up the results. Publications based on that work deal mainly with the failure to confirm the hypothesis that the profound social change inherent in rural to urban migration would invariably create mental health risk. Social change alone was not inevitably accompanied by mental health risk. However, social change combined with blocked opportunity created increased risk not only for mental disorder but for elevated blood pressure.

In 1975, I decided to return to Canada, and took up a professorship at the University of

British Columbia. Thanks to a National Health Research Scientist award from the Canadian government, I was able to protect myself against too many clinical and administrative responsibilities and concentrate on research. In 1981, two UBC colleagues – Dr Phyllis Johnson and Dr. Richard Nann -- and I initiated the Refugee Resettlement Project, a study of a large community sample of Southeast Asian “Boat People” who fled that troubled peninsula between 1979 and 1981, and were resettled in Vancouver, British Columbia. This became a ten-year longitudinal study which I believe is the longest-lived study of its kind conducted to date. Publications based on this work deal with the supportive mental health effects of the like-ethnic community, changes in employment patterns over time, and differential opportunities for men and women. My early observations about racial discrimination no doubt had something to do with my inclusion of its effects on the mental health of newly settling refugees in the study, as well as an interest in the effects of ethnic identification on mental well-being. I think that our research on the defense mechanism of suppression as a coping strategy in the aftermath of catastrophe is one of the more interesting and original parts of this research. The idea arose out of observing the way in which people in refugee camps in Thailand and Hong Kong handled their perceptions of time while they were waiting to be relocated to Canada. We developed a simple test of time perception that could be administered as part of our epidemiological surveys. I summarized many of our findings in a book called *Strangers at the Gate*. I received a Rockefeller Foundation Resident Scholar Award in 1995, which made it possible to spend a responsibility-free month at a beautiful estate in Bellagio, Italy, where all I had to do was concentrate on writing my book. It was published in 1999. My colleagues and I are, however, continuing to mine this seemingly inexhaustible trove of data and to publish our results in journals.

While the Refugee Resettlement Project was going on, I was also funded by the National Health Research Directorate Program of Canada, the National Institute of Mental Health and the WT Grant Foundation to carry out the *Flower of Two Soils*, a study of mental health and academic performance among Aboriginal children on two United States reservations and two Canadian reserves. I was very pleased to be able to work with outstanding US colleagues, including Spero Manson, Bill Sack, and James Shore, on this project. One of our main publications showed that teacher expectations subsequently affected children’s mental health and performance, and that children’s performance in turn predicted future teacher perceptions – a classic picture of reciprocal cause and effect, and a demonstration of the power of teachers to affect the mental health and academic futures of their students.

Nowadays, there is much talk about making research relevant to policy and practice. In 1986, I was privileged to play a small role in the policy world by chairing a federal government task force on the mental health of immigrants and refugees in Canada. We received written depositions, conducted oral hearings over the course of two years, and then, in 1988, issued our task force report called *After the Door Has Been Opened*. It contained a series of recommendations that we were sure the government would be eager to implement. Instead, my colleagues and I learned how slowly and painfully change comes about. Although I don’t think that the federal government ever directly implemented any of our recommendations, the report did have its uses: people tell me that even today they use it to advocate for change within local mental health institutions and at different levels of government.

In 1991, I accepted an invitation from the University of Toronto Department of Psychiatry to found the Culture, Community and Health Studies Program, an

interdisciplinary research initiative that I continued to head until 2003. I also became the first David Crombie Professor of Cultural Pluralism and Health, a position endowed in large part by the Canadian government's Department of Multiculturalism. I was also appointed founding director of CERIS, the Toronto Joint Centre of Excellence for Research on Immigration and Settlement. Having concluded my term as director, I continue my affiliation with CERIS as a senior scientist at the Centre.

In 1999, I obtained funding for a study of the possible role of resettlement stress in helping to explain elevated risk of tuberculosis among immigrants and refugees in Canada. I hired Owens Wiwa, a refugee doctor from Nigeria as research director for the project. One day, he invited me to come back to Nigeria with him to attend what he described as a small family funeral for his brother. I felt honored to accept. Just before we left, I discovered that Owens's brother was the famous Ken Saro-Wiwa, writer, politician and activist who had been unjustly hanged in 1995 because of his outspoken resistance to the collusion between international oil interests and a corrupt Nigerian government. When we got to Nigeria, we found out that the government, which had promised to return the body to the family, had reneged. The small family funeral became an international event, with 100,000 people gathering to express indignation and solidarity. My husband, Tim, subsequently wrote a biography about our friend that describes Owens's heroic pursuit to recover the body and return it to the family village, a pursuit that eventually reached a successful denouement. It's a wonderful book about love and personal heroism pitted against greed and corruption, called *The Politics of Bones*. The *Globe and Mail*, Canada's national newspaper, named it one of the 100 best books for the year.

I'm very proud of Tim's work. My first marriage didn't turn out well, but it did

produce three extraordinary sons, and, more recently, two adorable grandchildren. The second marriage, the best thing I've ever done, has produced twin boys. Another of the best things we've done was to buy a 600 year old house in southern France. We now go there twice a year with our two little boys to bask in the sun of Provence, eat great food, drink the wines and hang out with an ever-increasing circle of wonderful friends.

Another product of that initial sad trip back to Nigeria was the creation of a joint University of Port Harcourt Nigeria/University of Toronto centre to enhance health capacity in the Niger Delta region of the country. Working with our colleague at Port Harcourt, Professor Nimi Briggs, Owens Wiwa and I have received funding for two mental health oriented projects conducted out of the centre and there is now a major AIDS-related initiative as well.

In 2001, I had a unique experience. For the first, and only time in my career, a community approached me and asked me to study them. The Tamil community was concerned about what they perceived to be a high rate of suicide and of depression. They wanted to understand why, and they wanted data to help them. With funding from the Canadian Institutes of Health Research, we conducted an epidemiological survey of about 1600 Tamil adults living in Toronto. We plan to release the results to the community in the very near future and then to prepare reports for scientific journals.

Aside from the Nigeria and Tamil projects, my major current preoccupation is the New Canadian Children and Youth Study, a longitudinal investigation of the health, mental health and development of more than 4,000 immigrant and refugee children and their families from sixteen different ethnocultural groups living in six major cities across Canada. One of the sixteen communities is the Ethiopian community of Toronto. Taking advantage of a joint

program involving the University of Toronto and Addis Ababa University, I initiated a study with three Ethiopian colleagues in which we are comparing the Ethiopian children in our Canadian sample with a matched sample of children in Addis Ababa. I'm lucky to have an extraordinary groups of colleagues working with me on the projects, including Bob Armstrong in Vancouver, Linda Ogilvie in Edmonton, Jacqueline Oxman-Martinez in Montreal, Feng Hou in Ottawa, and Anneke Rummens, Laura Simich, Haile Fenta, Priya Watson, Clare Pain and Hayley Hamilton in Toronto.

I continue to be interested in the interface between research and policy, but I believe firmly that the general public is and must be the final arbiter of the value of both. In what I hoped would be a contribution to informing public debate about immigration in Canada, I developed a 12 part radio series that was broadcast on public radio in Ontario and Alberta in 1999. Two years later, colleagues from the media world and I developed a curriculum about immigration, resettlement, identity and discrimination for elementary school children. Following that, we developed a similar curriculum for high school students. The Department of Citizenship and Immigration Canada distributed the curricula to all public schools in Canada, and then redistributed it after 9/11. I was honored to receive a Queen's Golden Jubilee medal from the Senate of Canada for these educational materials, and even more honored to be awarded the Order of Canada in 2004.

Regina, Saskatchewan, where I spent my first 16 years has changed a lot. People tell me it's a much better place now. Although I have changed too, I'm still interested in questions and ideas that formed during my early days in that place – questions about racial discrimination, personal identity, community and being an immigrant. I plan to continue to work on these issues while also looking forward to new surprises that I'm sure are on their way.



***Francis G. Lu, M.D.***

*Professor of Clinical Psychiatry  
University of California, San  
Francisco*

I was born in San Francisco of Chinese immigrant parents in 1949. My father, born in 1916 near Shanghai, had obtained a medical degree at Tonjii University and came to the US to study pharmacology at Stanford. My mother, born in 1922 in Canton, came to study history. But the Chinese revolution made it unsafe for them to return, so they married and remained in the United States.

I grew up in New Jersey and Maryland as an only child and often the only Asian child in the schools I attended. Although my parents held onto Confucian values, I was more of a fast assimilator. I graduated from Columbia College, Dartmouth Medical School, and the Mt. Sinai (NY) psychiatry residency program. While psychiatry residency training at that time was devoid of cultural issues, I had the good fortune of having as a supervisor Gerald Epstein, MD, who opened my eyes to transpersonal psychology.

After completing residency training, I moved to San Francisco, in 1977, partially to have more opportunities to learn about

these perspectives. In May 1978, I attended a five-day residential seminar at Esalen Institute on “Hinduism and Buddhism in Oriental Art” given by Joseph Campbell, the great scholar of mythology. This seminar led to a transformative epiphany; it convinced me that my purpose in life was to bring together in some way the East and the West.

Since 1977, I have been an inpatient clinician, educator, and administrator in the UCSF Department of Psychiatry at San Francisco General Hospital (SFGH). As a Professor of Clinical Psychiatry, I have recruited, supervised, and mentored a generation of residents and junior faculty. I have also provided leadership for cultural competence and diversity at UCSF/UC, the California Department of Mental Health, SAMHSA Center for Mental Health Services the Office of the Surgeon General, HHS Office of Minority Health, HRSA, SAMHSA Center for Mental Health Services, the California Endowment, the Templeton Foundation, APA, and other professional organizations.

I am also the Director of the Cultural Competence and Diversity Program, Department of Psychiatry, San Francisco General Hospital (SFGH). SFGH is the only acute care public hospital in San Francisco and cares for the City’s MediCal, MediCare, and indigent population that are largely ethnic minority. Almost all the patients are initially involuntarily committed and severely mentally ill, often with concomitant substance abuse disorders. The inpatient programs also serve as cultural and public psychiatry training sites for medical students, psychiatry residents, and trainees of other disciplines.

In 1980, I founded the Asian Focus Psychiatric Inpatient Program, which served as a model for five other programs serving Black, Latino, women, gay/lesbian and HIV patients. In 1987, the APA awarded these programs a Certificate of Significant Achievement. In 1991, UCSF awarded

three SFGH Department of Psychiatry faculty, including myself, the Dr. Martin Luther King, Jr. Award for “extraordinary leadership and inspiration in furthering the goal of achieving ethnic diversity within the UCSF community” for the development of these programs. In 1999, the American College of Psychiatrists awarded UCSF the Creativity in Psychiatric Education Award “given in official recognition of creativity in addressing significant educational issues and sustained commitment to excellence in psychiatric education that can serve as a model for other programs.”

As a senior faculty member of the UCSF Department of Psychiatry, I provide leadership in diversity for the UCSF and UC system-wide. From 2002 to 2006, I was a member of the Equal Opportunity Committee of the UCSF Academic Senate and chaired it from 2004 to 2006. Also from 2004 to 2006, I was the UCSF representative to the system-wide Academic Senate University Committee on Affirmative Action and Diversity (UCAAD); in the 2007-2008 academic year, I am the Vice-chairperson. I also served four years on the UCSF Chancellor’s Advisory Committee on Diversity and chaired the Faculty Subcommittee for two years.

As a Distinguished Fellow of the American Psychiatric Association (APA), I have contributed to the areas of cultural psychiatry, psychiatric education, media and psychiatry, and the interface of psychiatry and religion/spirituality through numerous presentations and more than 70 publications. I have presented at every APA annual meeting since 1984, and began my 20-year work with the APA on the APA Committee of Asian-American Psychiatrists (1987-1993), which I chaired for 3 years. As a member of the Scientific Program Committee (1992 to 2000), I chaired the Media Subcommittee for 6 years. I was awarded the 2001 APA Kun-Po Soo Award for significant contributions toward understanding the impact of Asian cultural

heritage in areas relevant to psychiatry, and in 2002 I received an APA Special Presidential Commendation from President Richard Harding for work in cross-cultural psychiatry.

Under five APA Presidents from 2002 to 2007, I chaired the APA Council on Minority Mental Health and Health Disparities, which participated in developing several APA initiatives: 1) hiring a full-time director of the Department of Minority and National Affairs, 2) APA Action Plan for Reducing Mental Health Disparities, 3) APA's support of affirmative action in the Supreme Court case *Grutter v. University of Michigan*, 4) APA Resource document on Religious/Spiritual Commitments and Psychiatric Practice, 5) Updating the Membership Profile form to include languages spoken, greater specificity of race/ethnicity, and sexual orientation, 6) APA Position statement against racism and racial discrimination and their adverse impacts on mental health, 7) APA Position statement in support of legal recognition of same-sex civil marriage, 8) APA's support of the Language Access in Health Care Statement of Principles, authored by the National Health Law Program, 9) incorporating cultural and gender issues into the DSM-V development process.

I am a member of the Association for Academic Psychiatry (AAP), the American Association of Directors of Psychiatry Residency Training (AADPRT), and the Association of Directors of Medical Student Education in Psychiatry (ADMSEP). Since 2005, I have served on the Editorial Board of the APPI journal *Academic Psychiatry*. From 2006 to 2009, I am serving as the Senior Consultant for the AAP, and in 2006 was selected to be part of the inaugural group of AAP Distinguished Life Fellows.

In 2002, I was awarded the National Alliance for the Mentally Ill Exemplary Psychiatrist Award for exceptional cultural awareness and sensitivity. In 2003, I was

awarded the Association of Gay and Lesbian Psychiatrists Distinguished Service Award. I am a Distinguished Fellow of the Pacific Rim College of Psychiatrists as well as a member of the American College of Psychiatrists, the Society for the Study of Psychiatry and Culture since 1987, and the Group for the Advancement of Psychiatry, Cultural Psychiatry Committee, since 1994.

Since the publication of DSM-IV in 1994, I have disseminated the DSM-IV Outline for Cultural Formulation (Outline) through numerous lectures, publications, and a 58-minute training videotape/DVD "The Culture of Emotions" (2002) for which I served as the Executive Scientific Advisor. Since the Outline was placed in Appendix I of DSM-IV in 1996, many clinicians and trainees were not aware of this concise clinical tool that could help bring cultural issues in the clinical encounter to bear on differential diagnosis and treatment planning.

I was the lead author of one of the first articles on the Outline (1995), referenced as part of an updated literature review (2006). I contributed to a GAP monograph entitled *Cultural Assessment in Clinical Practice* (2002) about the Outline. I also served on the Workgroup on the Practice Guidelines for the Psychiatric Evaluation of Adults, 1st and 2nd editions; for the 2nd edition, I worked on having the Outline included in the text (2006). I have also participated in a CME course on the Outline at the APA Annual Meeting since 1995, chaired by one of my former UCSF residents, Russell Lim MD. I also contributed to the Forward and an annotated bibliography on cultural psychiatry for *The Clinical Manual of Cultural Psychiatry* edited by Russell Lim, MD, (2006), which is about the Outline.

Since 2000, I have served on the Board of Directors for the National Asian American and Pacific Islander Mental Health Association (NAAPIMHA) and as President of the Board since 2007. NAAPIMHA's

mission is to advocate on behalf of Asian and Pacific Islander mental health issues, to serve as a forum for effective collaboration and to network among stakeholders of community based organizations, consumers, family members, service providers, program developers, researchers, evaluators and policy makers, and nonprofit community-based organizations to develop comprehensive, culturally competent services to meet the needs of Asian and Pacific Islander communities. NAAPIMHA was awarded one of four SAMHSA Workforce Training Grants to Reduce Mental Health Disparities (2003-2006); I served on the Executive Committee to implement the curriculum at four national sites.

Since 1987, I have co-lead 20 film seminars at Esalen Institute; 16 have been co-lead with the Benedictine monk Brother David Steindl-Rast, who is originally from Austria. These seminars are described at [www.gratefulness.org/readings/healing\\_film\\_s.htm](http://www.gratefulness.org/readings/healing_film_s.htm). Of note, we share the same favorite film, “Ikiru” directed by Akira Kurosawa. An article about it, one of the most important articles I have written, can be found at [www.francislumd.com](http://www.francislumd.com)



***Afzal Javed, M.D.***

I graduated in medicine from the University of Punjab, where I studied at King Edward Medical College in Lahore, Pakistan, from 1971-1976. Despite having very limited exposure to mental health or psychiatry in medical school, I chose to do specialty training in psychiatry after completing my first degree in medicine. As in many other developing countries, teaching and training in mental health were not considered a priority and psychiatry was not a preferred specialty choice for many medical graduates in Pakistan at that time. There were many reasons for this “non popularity” of psychiatry among medical professionals, such as stigma related to mental illnesses, prejudice about their treatment, lack of awareness about the importance of the mind and its disorders, limited training facilities, and controversies about the scientific understanding and causes of many mental disorders. Isolation of mental health services in old asylums or mental hospitals was also a major factor in keeping psychiatry at a physical as well as emotional distance from other medical services and health professionals.

However, the scene in Pakistan was not that bad and there was a gradual shift in the practice of psychiatry that was bringing a new and more appealing face to this

emerging specialty. Shifting trends from the old-fashioned mental hospitals to newly established departments of psychiatry in general teaching hospitals, and the introduction of psychiatry as an important discipline in the new list of medical specialties were also proving very encouraging for many young doctors, who were becoming excited to join this challenging and relatively undiscovered specialty.

My initial training proved very stimulating for me and this first exposure to clinical psychiatry gave me a better insight about different dimensions of mental health and its practice in a country where treatment services were limited and unevenly distributed.

I must pay tribute to my first teacher and mentor in psychiatry, the late Prof Rashid Chaudhry, who taught me the basics of psychiatry, its application and the meaning of the well-being of the mentally ill, based on the philosophy of humanity, respect, compassion and kindness. I owe him a lot and will never forget these principles of care. These ideas are going to stay as guiding principles for me throughout my professional career.

This was also the time when I started getting more interested in culture and its relevance to mental health. These views gained more strength for me when I realized that people faced with the dilemma of finding mental health care and striving even for basic health care, were relying mainly on traditional and religious methods for the management of their psychological problems. I was also fascinated by the success stories of my patients getting cured by going to religious sites, traditional healers and spiritual leaders, rather than psychiatric facilities and psychiatric staff.

After getting initial postgraduate training in psychiatry in Pakistan, I got a chance to go to the UK for my advanced postgraduate

qualifications. While working in Edinburgh, I was actively involved in the activities of the Transcultural Society at the University Department of Psychiatry and acquired more awareness of the importance of cultural diversity and its role in understanding the broader dimensions of mental health. My thesis for the university degree again reflected my growing interest in this field. I investigated the mental health of overseas students at the University of Edinburgh and found out about impact of migration, issues about coming to a different culture, acculturation and adjustment in foreign countries. During the process of collecting data for my thesis, I was also involved in setting up some services for overseas students that again helped me in understanding the real issues in this area.

During my stay in UK, I also had a chance to spend some time at the Maudsley Hospital and the Institute of Psychiatry in London, and again my interest in culture and mental health remained a preferred area of interest for learning and training at this prestigious institution.

After spending three years and completing my advanced training in psychiatry in the UK, I returned to Pakistan and continued my university position in Lahore. In addition to the teaching responsibilities of my job, I also started taking keen interest in service development and planning teaching/training programs for general practitioners and other non-medical professionals in psychiatry. I was lucky to have the mentorship and the privilege of working with the late Prof Rashid Chaudhry, who, as the pioneer of psychiatry in Pakistan, had laid the foundations of modern psychiatry in this country. His vision about starting rehabilitation psychiatry in Pakistan also made him unique among the mental health professionals in Pakistan. It was an exciting experience for me to work with him and learn the fundamental realities of working in a developing country. It was troubling, that after working in the field, I realized that

most of my UK training was only theoretical learning, and that I needed to develop new concepts for working in a non-western developing country like Pakistan. This was indeed a great experience and helped me a lot in my professional development. It was also another good opportunity for me to examine the cultural values and requirements for Pakistani patients in their rehabilitation and it impressed me with the results of incorporating such needs in the provision of local mental health services.

This was also the time (late 1980s and early 1990s) when I became a member of the TP Section and got a chance to set up a Transcultural Psychiatry interest group in Pakistan. We started having seminars and academic meetings, highlighting the importance of cultural issues and their relevance in the provision of mental health services in our country. I encouraged other colleagues to explore further developments in this area.

I was also lucky enough to attend some of the regional and international meetings of the TP Section and other congresses addressing cultural issues. This certainly helped me a lot in shaping my views, concepts and practice in cultural psychiatry. In 1994, with the support and patronage of the late Prof Chaudhry, I was able to organize the first joint TP Section meeting in Pakistan (Lahore) and India (Chandigarh). Prof Varma, a senior colleague and active member of TP Section, was the organizer in India for this meeting. This was the first time that an academic meeting was arranged jointly by these two rival countries. This was also the first time, after a gap of many years, that the professionals of both these countries got a chance to get together and start talking about future collaborations in different areas of mental health. This interest continued and later on I was able to play an active role in the functioning of TP Section by organizing similar meetings (Lahore, Pakistan in 2004 and Delhi, India in 2005) and initiating

various other projects related to cultural psychiatry in these two countries.

I came back to the UK in 1996 and started my work in NHS and with the University of Warwick. I made use of this opportunity to get more involved in the development of the Transcultural Psychiatry services at regional and national levels in this country. I set up a group in the West Midlands and we started having formal meetings and academic activities highlighting the need to understand culture and cultural differences in managing mental health problems. Under this platform, in 2002, I organized the TP Section meeting in Coventry that proved very successful and paved the foundations of our Section's future activities in the UK. The success of this meeting also helped me to continue organizing several seminars on Transcultural Psychiatry in recent years. In 2003, under the leaderships of Prof Goffredo Bartocci and Dr Ronald Wintrob, the TP Section organized the first joint meeting of our Section with World Islamic Association for Mental Health in Narni, Italy. As an active member of both the organizations, I was able to help the TP Section with coordination of this historic initiative. This was a unique opportunity for all the participants of this meeting, that helped them to understand different cultural issues from the perspective of different religious beliefs and faiths. Subsequently, this collaboration helped us to participate in a similar meeting held in Cairo in 2003.

I have continued my interest in the field of cultural psychiatry and practiced different innovations in my clinical and academic positions. I also organized TP Section meetings in Lahore (Pakistan) in 2004 and in Delhi (India) in 2005. These meetings were well attended by a number of Section members and other mental health professionals.

I am currently working as a Consultant Psychiatrist & Honorary Associate Clinical Professor at Warwick Medical School,

University of Warwick, UK. My academic experience has been invaluable in my publishing more than 80 scientific papers and being the author of six books/monographs. Having a special interest in psychiatric research, I have been involved in planning, preparing and undertaking a number of research projects in several aspects of mental health, including transcultural psychiatry.

It has been a privilege for me to work with the Royal College of Psychiatrists, UK in different roles over the past many years. As Deputy Registrar of the College, I took a lead role for the Affiliates special committee and have also been involved with the Patients and Carers special committee. This has helped me in raising the profile of these groups at different national and international platforms. I have represented the College at many international meetings and have promoted the College policies; especially the importance of ethnic minority patients and carers' involvement in mental health programs. Being chairman of the College's Midlands Division, where a large number of ethnic populations live, I have been able to initiate a number of programs for these communities in public education, mental health awareness campaigns and other related areas.

On the international scene, I am currently working with a number of professional organizations; as Secretary of the WPA Section on Psychiatry in Developing Countries, Co-chair of the WPA Task Force on Brain Drain, as a Member of the WPA Nomination Committee, Member of the WPA Task Force on Disaster Management, Secretary General of the World Association for Psychosocial Rehabilitation (WAPR) and chairman of an international charity, Richmond Fellowship Foundation International. I was also a member of the Council on Global Psychiatry of the American Psychiatric Association (APA) and as founder and Secretary General of

South Asian Forum on Mental Health and Psychiatry (SAF).



**Prof. Dr. Wielant Machleidt**  
*Hanover Medical School*  
*Germany*

I studied medicine at the universities of Heidelberg and Berlin in the late 1960s and early 1970s. During those years I got involved in the 1968 student revolt against the “establishment”. Post-war Germany at that time was narrow-minded and conservative in its attitudes. Many professors at the universities had cooperated with the Nazi regime and were still in charge as directors of clinics and departments. My friends and I were committed to change and innovation at the medical faculties and we were actively opposed to “authorities of the old regime”. All in all this was a very fascinating time for me. I learned a lot about the international reform movements elsewhere in the world and “the winds of change”.

I was also lucky. The supervisor of the thesis for my medical degree, who was a critical scientist and citizen as well, got an

appointment to the chair of clinical neurophysiology at Hanover Medical School, which was one of the three reform universities in Germany established in the late 1960s. So I finished my studies in Berlin, passed my medical qualifying examinations and moved to Hanover Medical School to continue to work with my thesis supervisor.

I undertook training in neurophysiology and neurology in Hanover for several years, during which I was engaged in research on psycho-physiological methods in the identification of basic emotions. I finished my doctoral thesis in medicine in 1975.

After that I was attracted to modern social psychiatry, which was at a high innovative standard at Hanover Medical School. So I completed my psychiatric, psychotherapeutic and psychoanalytic training at the Department of Psychiatry, following which I was appointed to the faculty of the Department of Psychiatry at Hanover Medical School, in 1983. By that time I had completed all my psychiatric and psychotherapeutic training and I was looking for new challenges.

That was when transcultural psychiatry came into the focus of my interest. The head of the Department of Psychiatry at Hanover had spent several years in Vietnam, as a lecturer at Hué University Faculty of Medicine and had done some comparative psychiatric research there. I became interested in this kind of research and was able to obtain funding for my first transcultural psychiatric field research project.

I planned to study the treatment of mentally ill Africans by traditional healers in remote rural regions, where western psychiatric influence was still unknown. My wife and I had a physician friend at that time, who was a development aid worker in Malawi, in south-eastern Africa, working in the outskirts of the capital of Lilongwe. From

him I got information about the existence of a well-developed traditional healing system in Malawi. Accordingly, we decided to do field research there. My wife and I, and our two children aged four and five, migrated for several months to Malawi.

For me and my family, this was probably the most fascinating encounter with a foreign culture we ever had. I had been in Japan before that, and later spent some time in China, but the “African mind” and its interactive emotional encounters strongly influenced and impressed us right from the beginning. We travelled all around the country, as well as the neighbouring countries of Zimbabwe, Zambia and Mozambique. We met very experienced traditional healers, including one who was living in Likoma Island in Lake Malawi, who had treated the president of Malawi.

I got involved in the healing practices and rituals used for the treatment of patients with psychosis, depression, epilepsy and psychosomatic disturbances. And I learned that the traditional healing practices used in Malawi were effective. In a one-year follow-up study which I performed with a psychologist I became friendly with, we could show that schizophrenic and psychosomatic African patients had a therapeutic outcome comparable to that in Germany, or even better, and without the use of psychopharmacological treatment.

So when I returned to Hanover, I realized that while I was in Africa, my professional views had undergone a metamorphosis. I had developed a critical and more detached ethnological view of standard western therapeutic methods and thinking. I was looking at western therapeutic rituals applied to mentally ill patients from an ethnic and emic point of view. This experience has had a sustained influence on my therapeutic and research work in the years that followed.

Being back in Germany and just having coped with the cultural re-adaptation, I received an appointment to be professor of psychiatry and deputy director at the psychiatric clinic of the University of Cologne. So I migrated from the “cool and clear” Nordic people of Hanover in Lower Saxony, to what was referred to as “the “most northern capital of Italy”, Cologne, with its Italian-like people living on the banks of the Rhine.

During the following years in Cologne I had the most exciting experiences due to my migration within the borders of Germany. My acculturation process was associated with a lot of stress and lasted for more than two years. It took that long for me and my family to become adapted to living in Cologne.

In 1994 I was appointed as professor and head of the Department of Social Psychiatry and Psychotherapy at Hanover Medical School. My family and I migrated back to Hanover.

The main priorities of my scientific interest were now integrated; psychotherapy of psychoses, evaluation of community mental health systems, and research in transcultural psychiatry and immigration.

My co-workers and I developed the regional community psychiatric care system of Hanover as a model associating the principles of easy access and culturally-sensitive integration of migrants into the regular psychiatric services. I formed a research group on transcultural psychiatry and migration which was very active in clinical work and research. We established guidelines for the treatment and integration of migrants into the regular mental health services well known in German-speaking countries as the “Sonnenberger Leitlinien” (Sonnenberg Guidelines).

Acting as the head of the Section of Transcultural Psychiatry and Migration of

the German Association for Psychiatry, Psychotherapy and Nervous Diseases (DGPPN) and being the president of the Ethno-Medical Centre of Hanover, it became possible to direct the focus of interest of the professionals in the field of mental health and the health care system in Germany to the needs and therapeutic requirements of migrants and asylum seekers who had immigrated to Germany. So we were able to make a contribution to a considerable improvement in the health and mental health care of migrants in our country.

In the years to come I will continue to contribute to the research work of Central European migration, including work on the nature of mental disturbances in migrants, the causes of its manifestations in the migration-process, culture-sensitive psychotherapy, and innovative prevention strategies. At the present time, in cooperation with the Ethno-Medical Centre, we are performing a study sponsored by the German government on prevention of addiction in migrants, testing the efficacy of several new approaches.

Beyond that I am still active in writing and publishing papers and editing books (up to now more than 200 papers and 20 books), most of them written and published in German. My most recent book on migration, edited in 2006, with the title “Die Sonnenberger Leitlinien”, focused on concepts and experiences in the integration of migrants with mental problems into the regular psychiatric-psychotherapeutic services in central and northern European countries.

There is a great demand for information processing on transcultural psychiatry and psychotherapy and culture-sensitive treatments in migrants for professionals in German-speaking countries, and I plan to continue my work in this field in the years ahead.

I confess that I am a bit jealous of colleagues who are able to write papers in English as fluently as in their mother-language. I continue to work toward that goal. Recently I published a paper in English, which was the editorial of the September 2007 issue of *Acta Psychiatrica Scandinavica* (116: 161-164, 2007) on alternative and unconventional treatment methods in migrants and citizens.

But what I prefer most, beyond my professional work, is adventurous travels to remote countries. My next trip has already been scheduled. Together with my son and a friend, I will travel to “the world’s end”, to Patagonia, in January and/February 2008, backpacking of course. I am eager to say “hello” to the “curanderos” in that part of the world and ‘set foot’ on Cape Horn.

I thank Ron Wintrob very much for his help in editing this bio-sketch.

Prof. Dr. Wielant Machleidt  
Dpt. Social Psychiatry and Psychotherapy  
Medical School of Hanover  
Carl-Neuberg-Str. 1  
Germany  
E-mail: [machleidt.wielant@mhhannover.de](mailto:machleidt.wielant@mhhannover.de)

## Synopsis of "Spirituality and Health"

Special issue of  
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Alexander Moreira-Almeida, MD, PhD.  
Professor of Psychiatry  
School of Medicine  
Federal University of Juiz de Fora (UFJF)  
Brazil  
Director of the Research Center in  
Spirituality and Health (NUPES) at UFJF  
e-mail: [alex.ma@ufjf.edu.br](mailto:alex.ma@ufjf.edu.br)

Spirituality and Health is a controversial subject that has received increasing attention in recent years from health professionals. Thousands of papers have been published in medical journals on this topic during the last two decades. This clearly suggests that academic medicine has become more aware of the importance of religious/spiritual issues to health. This large body of research has helped us to better understand the relationship between spirituality and health. Unfortunately, however, studies conducted in countries other than the USA are still a small fraction of the literature on this topic. There is an urgent need for transcultural studies on the relationship between religious/spiritual issues and health.

Another limitation is the scarcity of interdisciplinary approaches and of studies dealing directly with spiritual experiences. Usually the dimensions of spirituality investigated are limited to religious practices and beliefs. There is an emphasis on sociological and epidemiological approaches, while the investigation of spiritual experiences is often neglected.

With these points in mind, I accepted the challenging invitation to be the guest editor of a special issue on "Spirituality and Health" of Revista de Psiquiatria Clínica (Journal of Clinical Psychiatry), a Brazilian psychiatric journal that has been published by the University of São Paulo for more than 30 years). I tried hard to make this issue as scientifically rigorous and as comprehensive as possible, comparable to the standards of scientific investigation in any other field.

This special issue contains 18 papers, written by almost 40 authors with very diverse backgrounds, from Brazil, USA, and UK. They included investigators of the philosophy of science, history, psychiatry, psychology, neurology, cardiology, nursing, psychobiology and geriatrics.

In addition to providing an overview of the current mainstream research done in the field, this issue includes several papers on relevant, but still understudied, topics on spirituality and health; topics such as trance and possession states, as well as spiritually based clinical interventions.

The issue starts with the foreword "Religion, spirituality and psychiatry: a new era in mental health care" by Harold Koenig. It is followed by papers dealing with epistemological, methodological and historical aspects of investigations related to spiritual experiences that are at the roots of almost all religions and spiritual traditions: shamanism and altered states of consciousness. After that, there are two original studies presenting innovative investigations of spiritually based interventions developed by Brazilian researchers.

Several papers review the evidence available regarding spirituality and substance use, pain and palliative care, physical health, psychotic disorders, quality of life, and psychotherapy. Religious coping and studies of the clinical implications of near death experiences are also reviewed.

The issue ends with a discussion about the meaning of the word spirituality and a short autobiography of Ian Stevenson, a pioneer researcher of spiritual experiences from the University of Virginia who died in February, when this special issue was in press.

This journal can be accessed online in both English:

[www.hcnet.usp.br/ipq/revista/vol34/s1/en/index.html](http://www.hcnet.usp.br/ipq/revista/vol34/s1/en/index.html)

and Portuguese:

[www.hcnet.usp.br/ipq/revista/vol34/s1/index.html](http://www.hcnet.usp.br/ipq/revista/vol34/s1/index.html).

Because this issue is bilingual, and it is indexed on several international databases (PsycINFO, EMBASE, Scopus, SciELO, LILACS, SIIC) we hope this issue will reach a wide audience and help to develop an international perspective on spirituality and health.

I conclude this synopsis with the last paragraph of my editorial for the issue: "Studying spirituality scientifically is a very exciting, although somewhat precarious enterprise. This is a field filled with prejudices, with biases for and against spirituality. Many people offer opinions on the topic, but usually these opinions are not based on an in-depth analysis of the evidence available. It is easy to slip into an intolerant and dogmatic skepticism, or to proclaim a naive acceptance of doubtful claims. Regardless of whether we hold spiritual or materialistic beliefs, religious or anti-religious postures, we have a responsibility to explore the relationship between spirituality and health in order to improve our knowledge and our care of human beings. Through this challenging task, it would be useful to keep in mind the following words of Karl Popper, one of the most renowned philosophers of the 20th century: "In searching for the truth, it may be our best plan to start by criticizing our most cherished beliefs..." (p.6) "I believe that it would be worth trying to learn something about the world even if in trying to do so we should merely learn that

we do not know much. This state of learned ignorance might be a help in many of our troubles. It might be well for all of us to remember that, while differing widely in the various little bits we know, in our infinite ignorance, we are all equal.” (p.29) 1

1 Popper, K. R. (1995) *Conjectures and Refutations – The Growth of Scientific Knowledge* (London: Routledge).

# INTERNATIONAL SUMMER SEMINAR: HEALERS AND DOCTORS IN THE ANDES

New Program in Transcultural Psychiatry



*Runajambi, Institute for the Study of Quichua Culture & Health*  
[www.runajambi.org](http://www.runajambi.org)

*by Lise Bouchard, Ph.D.*  
*Director, Dept. of Research, Runajambi*

This summer, Runajambi (Institute for the Study of Quichua Culture and Health) in Otavalo, Ecuador held a unique International Summer Seminar. Students and professors from Randolph College in Lynchburg, Virginia, USA, attended the two-week experiential seminar at Runajambi, from June 2 to 16.

The participants had the opportunity to study the Quichuas' health and traditional medical system. They explored the commonalities and differences of Quichua medicine/psychiatry and the Western biomedical system, as well as their interaction in the Ecuadorian context. The program took place in the Quichua milieu, providing the participants with a unique intercultural learning experience.

The seminar included lectures, readings and class discussions. It covered the following topics: (1) Quichua theories of illness; (2) Quichua health status and major culture-bound syndromes; (3) common roots and equivalent efficacy of Quichua healing interventions and Western psychotherapy; (4) underlying neurobiological mechanism of Quichua and Western healing methods; (5) elements of Quichua phytotherapy; and (6) healer-physician collaboration. The participants also had the opportunity to visit

Taita José Manuel Córdova, a Quichua healer from Ilumán, a community renowned in the Andes for its hundreds of indigenous healers. He performed a traditional healing session with a student volunteer.



Taita José Manuel Córdova during a healing session with a student volunteer.

The participants also went to the San Luis de Otavalo Hospital, where they were received by Dr. Terán, the new medical director, and first Quichua physician to be appointed to that position. The lack of infrastructure at the hospital, and the emptiness of the rooms struck them. It was evident that Quichua patients avoided going to public hospitals. They soon became aware of the tension in the workplace between the Latino

employees and their new Quichua medical director.

Students and professors visited two public community health centers. The two facilities were closed and deserted, despite the fact that the visit occurred during advertised hours of operation.

Lastly, they went to a medicinal plant market. The merchants explained to them the use and healing virtues of several plants. Among them are the “palo pistola” (from the Amazonian region, used to alleviate cough) and others with psychotropic properties.



A traditional rural house in the Ecuadorian highlands

Through daily classes, participants acquired basic knowledge of Quichua language and culture. In addition, they visited the ethnological museum of Caranqui, the town where Atahualpa (the last Inca emperor) was born, and the “El Obraje” museum of weaving in Otavalo. Students observed ancient pottery, as well as traditional agricultural and weaving techniques of the Quichua civilization.

On their return to the USA, the students presented interesting research papers exposing their reflections on what they learned about Quichua healers and doctors in the Andes during the seminar. Two of the papers were entitled: “The Possibility of Effective Collaboration between Traditional and Modern Medicine” by Justine Wiley, and “Healers and Doctors: Collaborations in the Field of Psychiatry” by Rachel Martinez.

Starting next summer, Runajambi will offer this seminar annually to all students, health professionals, and faculty interested in health issues and healing practices of the Indigenous Peoples of the Andes. More information is available at:

<http://www.runajambi.net/HDAseminar.htm>

Runajambi, Institute for the Study of Quichua Culture and Health, is a nonprofit Quichua (Inca) organization inaugurated in 1990. It is the first Quichua health research institution in Ecuador devoted to the physical and mental health of the First Nations of the Andes. Mario Incayawar MD, a Quichua physician and cultural psychiatrist, is Medical Director of Runajambi.