

CONTENTS	Page
2nd World Congress	1
Link with Transcultural Psychiatry	2
In this Edition	2
Chronic Fatigue and Ethnicity	4
WPA Demoralization Cancer Grant	5
Cultural Formulation Research	7
New Member Symposium	9
Meet Our New Members	9
Dr. Kinzie's Book Notes	26
Research in Israel	30
Future International Conferences	32
Courses in Cultural Psychiatry	42

2nd World Congress of Cultural Psychiatry: Report to TPS Members

Ronald WIntro, M.D.

Chair WPA-Transcultural Psychiatry Section

I am writing this report while still experiencing the warm glow of the Umbrian sun and the numerous buoyant contacts with many colleagues and friends who participated in the 2nd World Congress of Cultural Psychiatry (WCCP), held in Norcia, Italy, September 27-30. There were more than 250 people who came from all over the world to attend the congress, and to enjoy the ambience of a walled Umbrian medieval town; one celebrated for its location in a national park, surrounded by steep hills and mountain trails, and equally well known in Italy for its good food and

regional wines. The bounty of Umbria was evident to all at the congress' opening reception and throughout our time in Norcia.

The intention of choosing Norcia as the venue for the conference was to enable the participants in the congress to not only present some of their work during congress symposia, but to talk about their interests and activities in cultural psychiatry as they encountered other congress participants in the quiet streets, public squares, cafes and restaurants of Norcia throughout the three days of the congress. This unique feature was very much appreciated by those who attended the congress.

There were nine plenary sessions and 40 symposia during the course of the congress, which opened with a compelling presentation on the medical and ecclesiastical significance of Norcia over more than a thousand years of history. During the first morning of the congress, plenary presentations were given by Goffredo Bartocci, M.D. on "The Cultural Brain and Living Societies", by Wolfgang Jilek, M.D. on "The History of Cultural Psychiatry from the 1800s to 1971", by Laurence Kirmayer, M.D. on "Current Trends in Cultural Psychiatry" and by Joe Westermeyer, M.D. on "Contributions of Cultural Psychiatry to International Psychiatry".

Among the plenary symposia, topics covered included; "Science and Faith; Cultural

Continued page 3

Transcultural Psychiatry

Ronald WIntrob, M.D.

Chair WPA-Transcultural Psychiatry Section

There is an important development that has been completed and formalized in 2009. It is the designation of the journal *Transcultural Psychiatry* as the 'official journal' of WPA-TPS. The agreement related to this designation has been negotiated over the past year between WPA, WPA-TPS, the Division of Social and

Continued page 3

Visit the *Transcultural Psychiatry* website:

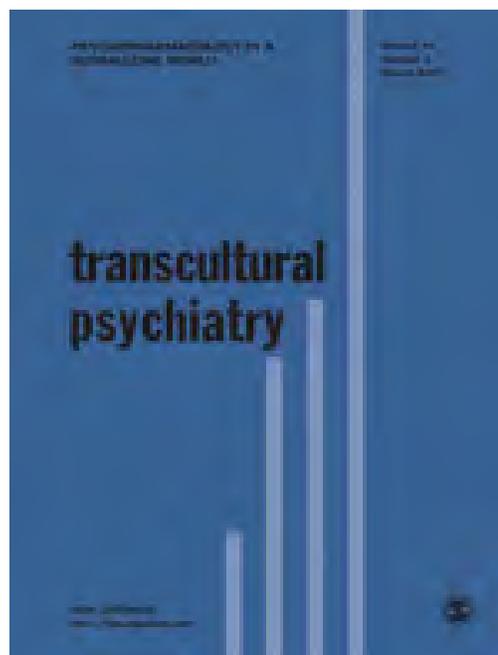
<http://tps.sagepub.com>

Transcultural Psychiatry Table of Contents:

<http://tps.sagepub.com/current.dtl>

In This Edition: A Note From the Editors

Welcome to Volume 4 Issue 2 edition of the Newsletter. It has certainly been an exciting year for Cultural Psychiatry. The recent World Association of Cultural Psychiatry's Second World Congress of Cultural Psychiatry "Cultural Brain and Living Societies", held in Norcia, Italy was a great success. Professor Ronald Wintrob will provide a full report about the congress. Another great piece of news is that *Transcultural Psychiatry* has become the official journal of the WPA TPS.



In this edition we provide information about forthcoming conferences in 2010 and 2011. We present biosketches of seven new members of the section. Book Notes has four book reviews by Professor David Kinzie.

We are keen that the Newsletter is used as a forum for disseminating news about current research in cultural psychiatry. Here John de Figueiredo, M.D., D.Sc. describes a fascinating

Continued page 3

WPA -Transcultural Psychiatry Section Executive Committee 2008-2011

Ronald Wintrob, M.D. (USA) Chair
Fumitaka Noda, M.D., Ph.D. (Japan) Co-Chair
Rachid Bennegadi, M.D. (France) Secretary
Hans Rohlof, M.D. (Netherlands) Treasurer

Kamaldeep Bhui, M.D., Ph.D. (UK)
John De Figueiredo, M.D., D.Sc. (USA)
Mario Incayawar, M.D., M.Sc. (Quichua-Inca)
Mitchell Weiss, M.D., Ph.D. (Switzerland)
Xudong Zhao, M.D., Ph.D. (China)

WORLD HEALER EDITORIAL STAFF

Simon Dein, M.D. (UK) Editor ✉
Robert Kohn, M.D., M.Phil. (USA) Associate Editor
J. David Kinzie, M.D. (USA) Book Review Editor

Past issues at:

<http://www.wpa-tps.org/newsletter.htm>

In This Edition: A Note From the Editors

From page 2

study looking at demoralization and cancer. Sushrut Jadhav, M.D. describes his recently completed study of Cultural Formulation in London. Kam Bhui, M.D., Ph.D. discusses his review of ethnicity and chronic fatigue syndrome. Robert Kohn, M.D. gives an update on research from Israel. If you have any ongoing projects you would like included please send us a two page summary.

Formal teaching on cultural psychiatry has become more popular in the past decade. There are by now a number of courses and Masters Degrees being run worldwide. Please send us any information about courses being offered on any topic related to cultural psychiatry. Here we include information about two British Masters Degrees: University College of London and Queen Mary, University of London.

We hope you enjoy reading this edition.

Simon Dein, M.D.
Editor

Robert Kohn, M.D.
Associate Editor



2nd World Congress of Cultural Psychiatry: Report to TPS Members

From page 1

Psychiatry and the Study of Spirituality”, “The Influence of Culture in Psychiatric Diagnosis and Explanatory Models”, “Culture, Health and Well-being”, “Mental Health Effects of Disasters Among Ethnic Minorities”, “Progress in Apology and Reconciliation; a Future Role for

Cultural Psychiatry in Healing from Trauma”, “Culture, Disasters and Mental Health”, “Cultural Psychiatry in a Multicultural Society”, “Transcultural Aspects of Clinical Assessment, Diagnosis and Treatment of Immigrants and Refugees”, “Psychological Assessment and Care of Children and Adolescents in Different Cultures”, The Frontiers of Cultural Neuroscience”, “Cinema, Psychiatry and Mental Health”, “The Influence of Law and Culture on Psychiatric Practice, Patients’ Rights and Psychiatrists’ Responsibilities”, “Culture, Aging and Mental Health”, and “The Future of Cultural Psychiatry”.

The congress scientific program included two symposia organized WPA-TPS, each symposium comprising eight papers, on “Immigration and Acculturative Stress in an Era of Fear of

Continued page 4

Transcultural Psychiatry -

From page 2

Transcultural Psychiatry of McGill University, and Sage Publications. It stipulates that one issue of *Transcultural Psychiatry* each year will be devoted to a series of articles drawn from one or more symposia presented at a TPS-sponsored international conference on cultural psychiatry during that year. The first of these ‘special issues’ of *Transcultural Psychiatry*, devoted to the theme of “The Personal and the Professional in the Lives and Careers of Cultural Psychiatrists” is currently in preparation. Articles for this special issue are undergoing peer review. We anticipate publication of this inaugural ‘special issues’ of *Transcultural Psychiatry* in 2010.



2nd World Congress of Cultural Psychiatry: Report to TPS Members

From page 3

Terrorism” and on “Culture, Humor and Psychiatry”.

During the course of the WCCP, WPA-TPS also held a well-attended working meeting of the TPS executive committee, as well as a business meeting open to all congress participants, at which TPS activities and plans for 2010 and 2011 were reviewed in some detail. In particular, people were informed about the inaugural WPA awards to Sections for research projects initiated by Sections, either on their own or in combination with other WPA Sections. Two such projects were recently approved by Dr. Mario Maj, President of WPA, for funding of \$50,000 each; and one of the two awards went to TPS for its project titled; “A Cross-National Multi-Center Study of Depression, Demoralization and Functional Impairment in Cancer Patients”. The principal investigator of this project is John de Figueiredo, M.D., D.Sc., based at Yale University, who developed our TPS proposal along with co-investigators Giovanni Fava, M.D. at University of Bologna and

David Clarke, Ph.D. at Monash University in Melbourne, Australia. Details of this project are included in the report by Dr. de Figueiredo that is in this issue of World Healer, the TPS Newsletter.



Chronic Fatigue and Ethnicity

Kamaldeep Bhui, M.D., Ph.D
Barts and The London School of
Medicine and Dentistry

Unexplained physical complaints have been the subject of scientific study from diverse disciplinary perspectives. These are often understood to represent psychiatric illnesses, perhaps when the patient does not agree with a psychiatric diagnosis. These have also been understood to be idiomatic expressions of mental distress, or expressions of distress that are sanctioned in particular cultural groups. An alternative explanation is that these are manifestations of social strain, including disempowerment in society and poor social status.

Multiple somatic complaints remain poorly understood, and are often found in primary care presentations of people for ethnic minority groups, with specific emphasis on people from South Asian groups in the UK. Chronic Fatigue Syndrome (CFS), also called ME, is the subject of fierce debate about its etiology and treatment. It includes multiple somatic complaints, but often linked to some triggers like viral illness. Traditionally, it has been proposed to be less common among ethnic minorities and in culturally distinct groups, at one stage even being proposed to be more common in white women, and those in higher social positions and in busy and demanding work environments.

Continued page 5



Chronic Fatigue and Ethnicity

From page 4

Led by Professor Kamaldeep Bhui, a multidisciplinary team of researchers have been investigating prevalence and risk factors for CFS across ethnic groups in the UK, using a large data set of over 4000 individuals from six ethnic groups. We also undertook a review of the world literature. This Medical Research Council funded study now has publications. The systematic review included meta-analyses which show that compared with the White American majority, African Americans and Native Americans had a higher risk of CFS (OR 2.95, 95% confidence interval (CI): 0.69–10.4; OR = 11.5, CI: 1.1–56.4, respectively). Minority ethnic groups with CFS experienced more severe symptoms and were more likely to use religion, denial and behavioral disengagement to cope with their condition compared with the White majority (see <http://ije.oxfordjournals.org/cgi/content/short/dyp147v1?rss=1>).

We are now preparing the main epidemiological report from the study and a qualitative study of expressions of fatigue; these also challenge the conventional notion that CFS is rare amongst ethnic minority groups, suggesting there are distinct filters and obstacles to its recognition and treatment.

Research team: Sokratis Dinos, Bernadette Khoshaba, Deborah Ashby, Peter D White, James Nazroo, Simon Wessely and Kamaldeep S Bhui. A systematic review of chronic fatigue, its syndromes and ethnicity: prevalence, severity, co-morbidity and coping. *International Journal of Epidemiology*, doi:10.1093/ije/dyp147. IJE Advance Access published online on April 6, 2009.



TPS Awarded Grant By WPA For a Cross-National Multi-Center Study of Depression, Demoralization and Functional Impairment in Cancer Patients

John De Figueiredo, M.D., D.Sc.
Yale University

The Transcultural Psychiatry Section was awarded one of the two inaugural grants approved for funding by the World Psychiatric Association for research on topics related to the interrelations of psychiatry and medicine. The subjects in the study will be cancer patients recruited in participating centers located in the United States, Italy, and Australia. John M. de Figueiredo, M.D., D.Sc., Associate Clinical Professor of Psychiatry at Yale University School of Medicine, will be the Principal Investigator. Giovanni Fava, M.D., Professor of Psychiatry and Psychology at the University of Bologna, Italy, and David Clarke, Ph.D., Professor of Psychology, Psychiatry and Psychological Medicine at Monash University, Melbourne, Australia, will be co-principal investigators.

Numerous studies have assessed depression in cancer patients, reporting widely variable prevalence rates [1]. The study of depression in cancer patients can be quite challenging, partly because the symptoms range from sadness to major depressive disorder, partly because patients are exposed to a life threatening illness and its complications, and partly because it may be difficult to distinguish what may be homeostatic response to stress from a mental disorder or a result of cancer or its treatment [2]. A critical issue is the interpretation of the clinical presentation. Are the symptoms of depression of a cancer patient a sign of normal (“understandable”) reaction

Continued page 6

Demoralization and Cancer

From page 5

to stress, of non-specific (sub-threshold) distress, of clinical (supra-threshold) depression, or of demoralization? How is a normal (“understandable”) reaction to cancer influenced by culture? [3]

The distinction between depression and demoralization brings us closer to an understanding of the psychological distress of cancer patients. Demoralization has been described as the state of mind of a person deprived of spirit or courage, disheartened, bewildered, and thrown into disorder or confusion. Jerome D. Frank proposed that all forms of psychotherapy attempt to relieve demoralization and that the majority of patients who seek psychotherapy are demoralized, whatever their diagnostic label. Moreover, he pointed out that all psychotherapies share at least four effective features: a therapeutic alliance between the helper and the sufferer; a context or healing setting; a rationale, conceptual scheme or myth that provides a plausible explanation for the patient’s symptoms; and a ritual or procedure that requires the active participation of the healer and the sufferer and that is believed by both to be the means of restoring the patient’s health. According to Frank, these four features are the nonspecific ingredients of the process of healing [4]. Frank recognized that improvement in psychotherapy is multidimensional and that the key element in improvement is the patient’s own restorative process rather than the specific form of psychotherapy, thus highlighting the importance of the patient’s degree of resilience in his or her attempts to overcome demoralization [5].

Demoralization has been observed not only in psychiatric outpatients but also in medically ill

patients, first described by George Engel as the “giving up-given up syndrome” [6] and in acutely ill patients in emergency departments, where it was called “crisis” by Gerald Caplan [7]. A state of chronic demoralization was described as “social breakdown syndrome” by Ernest Gruenberg in patients with chronic mental illness [8]. The prevalence of demoralization in a community has been shown to be inversely associated with the degree of sociocultural integration. That is, persons less integrated in their social groups are more demoralized and more likely to suffer from psychiatric disorders than those more integrated; even when the former have fewer stressful life events than the latter [9, 10]. Furthermore, the former are also more likely to see a doctor or to be hospitalized for physical illness than the latter [11].

To further characterize the concept of demoralization, Dr. de Figueiredo, who had been a student of Dr. Frank, proposed several years ago that the clinical hallmark of demoralization is “subjective incompetence”, a self-perceived incapacity to perform tasks and express feelings deemed appropriate in a stressful situation, resulting in pervasive uncertainty and doubts about the future. Depression and other forms of distress may or may not be associated with subjective incompetence. Demoralization is viewed as involving both non-specific distress and subjective incompetence [12-14].

The objectives of the proposed research are to determine if: (a) subjective incompetence is directly correlated with functional impairment and predicts functional impairment; (b) subjective incompetence is a necessary component of demoralization; and (c) depression and subjective incompetence are separate components of demoralization. Cross-national

Continued page 7

Demoralization and Cancer

Cultural Formulation Research

From page 6

Sushrut Jadhav, M.D.
University College London

and cross-cultural differences in the pattern of results will be examined and interpreted.

Due to lack of measures of subjective incompetence, while demoralization has been documented in cancer patients, the relevance of subjective incompetence to this patient population has not yet been demonstrated. Two scales for subjective incompetence have recently been developed by Dr. de Figueiredo and his colleagues and shown to have reliability and validity, thus opening up the possibility for studying the relationship of distress and subjective incompetence to perceived stress and social support [15]. The now-funded WPA-TPS study will be using those two subjective incompetence scales as well as other measures such as the demoralization criteria that are part of the Diagnostic Criteria for Psychosomatic Research (DCPR) [16], the demoralization scales developed by Bruce Dohrenwend [17] and David Kissane [18], and scales to measure perceived stress, level of social support, resilience, and quality of life. The Karnofsky performance status criteria and index will be used to measure functional impairment [19].

It is anticipated that this project will be carried out from March, 2010 through July, 2011. Reports on the methods and results of this study will be submitted for publication in professional journals and presented at cultural psychiatry conferences in 2011 and 2012.

Continued page 8

Extensive research in cultural psychiatry argues for the critical importance of delivering culturally sensitive care in clinical psychiatric settings worldwide. To date, the clinical efficacy of cultural interventions in psychiatry remain confined to single case studies and service development outcomes. A systematic evidence based analysis of how cultural interventions influence effective clinician-patient engagement and illness outcome is absent from the published literature. The DSM-V white paper calls for an urgent assessment of the “systematic use, usefulness, and relevance of Cultural Formulations in psychiatry”. A combination of official DSM-IV Cultural Formulation guidelines, the UK Explanatory Model Interview Catalogue, together with existing theory in medical anthropology and ethnographic field work, shaped the development of a structured Cultural Formulation Interview for In-patient Care. The clinical efficacy of this interview was further tested by conducting a randomized controlled intervention trial with 60 subjects in 4 acute in-patient units in an inner London psychiatric hospital. Outcome variables included quantitative measures: Brief Psychopathology Rating Scale, Patient Satisfaction Ratings, and other locally developed methods to assess clinical gains from the Cultural Formulation interviews. Statistical analysis to establish the efficacy of this approach was complemented by qualitative thematic findings that emerged from individual study subjects.

While this procedure aimed at therapeutic

Continued page 8

Cultural Formulation Research

From page 7

application of patients cultural narratives, a pilot study established early on that such accounts were not incorporated into the delivery of their clinical care. Simultaneous hospital ethnography of the clinical research site was therefore aimed at complementing individual interviews, and investigating the facilitators and barriers for delivering culturally sensitive care. The clinical ethnography contextualized the randomized controlled trial, further examined how illness is shaped by the wider clinical and management culture of health services, and provided newer understanding and treatment pathways. The study was carried out with the full support and input of service users (patients), who were of the view that if nothing else it offered a much better engagement tool than the usual clinical interview. The extensive data from this project are currently being analyzed.



Demoralization and Cancer

From page 7

REFERENCES

1. Massie MJ. Prevalence of depression in patients with cancer. *Journal of the National Cancer Institute Monographs* 2004; 32: 57-71
2. Coups EJ, Winell J, Holland JC. Depression in the Context of Cancer. In: *Biology of Depression. From Novel Insights to Therapeutic Strategies*, Licinio J, Wong M-L (Eds.), Wiley-VCH GmbH & Co. KGaA, Weinheim 2005 pp. 365-385 (Cf. p. 365-367)
3. Maj M. Are we able to differentiate between true mental disorders and homeostatic reactions to adverse life events? *Psychotherapy and Psychosomatics* 2007; 76: 257-259
4. Frank JD, Frank JB. *Persuasion and Healing, A Comparative Study of Psychotherapy*, The Johns Hopkins University Press: Baltimore and London, 1991.
5. de Figueiredo JM. Editorial. Demoralization and psychotherapy: a tribute to Jerome D. Frank, MD, PhD (1909-2005). *Psychotherapy and Psychosomatics* 2007; 76:129-33
6. Engel GL. A psychological setting of somatic disease: the "giving up-given up complex". *Proceedings of the Royal Society of Medicine* 1967; 60: 553-555
7. Caplan G. *Principles of Preventive Psychiatry*. New York, Basic Books, 1964
8. Gruenberg EM. The social breakdown syndrome and its prevention. In: *American Handbook of Psychiatry*, Caplan G (Ed.). Basic Books, Inc. New York, Basic Books, 1974, pp 697-711
9. Leighton A. *My Name is Legion: Foundations for a Theory of Man in Relation to Culture*. Basic Books, Inc. New York 1959
10. de Figueiredo JM. The law of sociocultural demoralization. *Social Psychiatry* 1983; 18: 73-78
11. Myers JK, Lidenthal JJ, Pepper MP. Life events, social integration and psychiatric symptomatology. *Journal of Health and Social Behavior* 1975; 16: 421-429
12. de Figueiredo JM, Frank JD. Subjective incompetence, the clinical hallmark of demoralization. *Comprehensive Psychiatry*, 23(4): 353-363, 1982
13. de Figueiredo JM. Some issues in research on the epidemiology of demoralization. *Comprehensive Psychiatry*, 24(2): 154-157, 1983
14. de Figueiredo JM. Depression and demoralization: phenomenological differences and research perspectives. *Comprehensive Psychiatry*, 34(5): 308-311, 1993
15. Cockram C, Doros G., de Figueiredo JM. Diagnosis and measurement of subjective incompetence, the clinical hallmark of demoralization. *Psychotherapy and Psychosomatics* 2009; 78: 342-345
16. Fabbri S, Fava GA, Sirri L, Wise TN. Development of a New Assessment Strategy in Psychosomatic Medicine: the Diagnostic Criteria for Psychosomatic Research. In: *Psychological Factors Affecting Medical Conditions. A New Classification for DSM-V*, Porcelli P, Sonino (Eds.). Karger: Basel, *Advances in Psychosomatic Medicine* 2007; 28:1-20



Research Symposium For New Members

Ronald WIntro, M.D.

Chair WPA-Transcultural Psychiatry Section

During the past year, eight new members have joined the TP Section. Seven of them have prepared bio-sketches for the November 2009 issue of our TPS Newsletter. We welcome their membership in the Section and look forward to their active participation in the life of TPS in the years ahead. To encourage just that, we plan to include a symposium for new members to present their research, as part of the scientific program of the TPS-sponsored international conference on cultural psychiatry, to be held in Amsterdam, in June, 2010.

We plan to include similar symposia for new members' research at all future TPS-sponsored international conferences on cultural psychiatry.

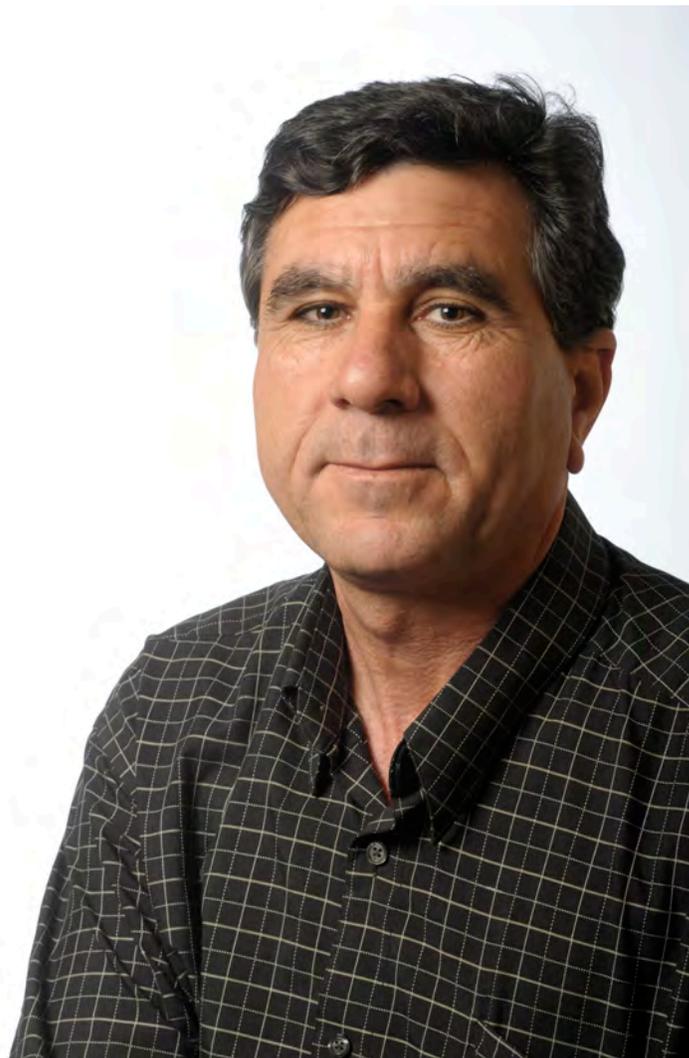
Meet Our New Members

Alean Al-Krenawi, Ph.D.

I have a BA degree from Ben-Gurion University of the Negev, an M.A. in Social Work from Hebrew University of Jerusalem, and a Ph.D from the University of Toronto. Between 2004-2008 I served as the Chair of the Charlotte B. and Jack J. Spitzer Department of Social Work at Ben-Gurion University of the Negev where I have the rank of Professor.

My research interests include multicultural mental-health and social work with indigenous populations. I have conducted studies in Israel, Canada, Palestine and other Arab countries. In

the last few years I am expanding my work to several African countries as well. I have completed two books, the first of which was published in Israel (2000) and deals with Arab ethno-psychiatry. My second book, titled: *Helping Professional Practice with Indigenous People: The Bedouin-Arab Case*, was published by American Universities Press (2009). In addition I am a co-editor of *Multicultural Social Work in Canada: Working with Diverse Ethno-Racial Communities*, published by Oxford University Press (2003). Currently, I am working on two additional books; *Islam and Social Work*, which will be published by Columbia University Press, and *The Psychosocial Impact of Political Violence on Adolescents: The Israeli –Palestinian Case*.



Continued page 10

Meet Our New Members

Alean Al-Krenawi, Ph.D.

From page 9

I have authored numerous book chapters and academic peer reviewed articles. Recently published works appear/are about to appear in the *American Journal of Orthopsychiatry*, *British Journal of Psychiatry*, *Child Abuse and Neglect*, *Current Opinion in Psychiatry*, *Family Process*, *The Journal of Comparative Family Studies*, *Social Psychiatry*, as well as other professional forums.

Betina Mariante Cardoso, M.D.

I begin this essay with reflections from April 2009, when I had my first exposure to an event organized by the WPA-Transcultural Psychiatry Section. It was during the WPA International Congress, in Florence, Italy. I remember that it was a Saturday morning and I was very enthusiastic about attending the WPA-TPS sponsored symposium on “Culture, Humor and Psychiatry”. Humor had become a topic of personal interest to me, since five years ago, when I first encountered “L’Umoreismo”, by Luigi Pirandello, in an old bookstore in Borgo Stretto, Pisa, on a cloudy and rainy Sunday afternoon. Pisa is a city I also carry in my inner baggage when I close my eyes and feel the ambience of Italy enveloping me. So I opened the book at Caffè dell’Ussero, a magical place for reading and sipping an espresso. Reading Pirandello’s *Humor* I was enchanted by the subject, and wondered if or when I might see this issue given serious consideration at a psychiatry seminar, or at a symposium of a psychiatry conference.

And so I turn to “that April morning”; that discussion about humor, culture and psychiatry I had been yearning to encounter, an interweaving of the themes sensitively done through humor in different cultures, and its influence on our clinical lives as psychiatrists. I walked in a different way when that morning ended, maybe thinking about the numerous patients and medical situations which evoked in me the need for understanding and expressing humor (in the right dose). And I experienced that morning a series of well thought out and enthusiastic presentations, and colleagues laughing from around the world placing culture, humor and their transcultural perspectives in psychiatry in the important place they deserve to occupy in our specialty.



In fact, ever since I was a medical student, and continuing since my graduation, I have always been interested in research focusing on the cultural roots of medicine. I have tried to apply that perspective in interviewing new patients, and in studying their functioning and coping, their perspectives about the world around them, their life-style. I could always perceive that the way they talked, the way they expressed themselves, revealed a lot about them; their

Continued page 11

Meet Our New Members

Betina Mariante Cardoso, M.D.

From page 10

language, their accent, their idiomatic expressions, and their world view. From the beginning of our clinical studies in medicine, when we are for the first time exposed to “real” patients, I tried to relate to each patient as a unique individual with a very particular face, body and life history, and I tried to understand everything he wanted to say about himself, his family, his thoughts about illness and disease and life style, his ways of coping with disease, patterns of behavior that he never even really thought about, because “it was always that way”, for everyone in his family and in his community.

I gradually realized how much I enjoyed that kind of study and practice, the doctor-patient relationship and its implications for effective treatment; the dialogues, smiles -and not so smiling faces-, responding to my long and exhausting interviews, just to get to know the patient beyond his ‘presenting problem’. And so I perceived that patients liked to be viewed in their whole, and they liked to talk about things that apparently did not matter, about their culture and thinking, but, going ahead, I discovered that kind of “chat”, I would say, “a serious chat”, was the part they liked most; because they needed it. They needed someone who would listen to their histories, talk to them and have the patience to go with them through the details and trials along the path of their suffering, during an extensive anamnesis.

Not surprisingly, this interest in the individuality and uniqueness of each patient’s values, experiences and life history led me to become a resident specializing in psychiatry, after three years of

trying to decide between psychiatry and other clinical specialties. But as I thought more deeply about what I really valued as a career in medicine, I realized my choice would have to be psychiatry.

In order to integrate psychiatry with clinical medicine, I undertook advanced training in Pain and Palliative Medicine, which taught me a lot about how intense and enduring can be the suffering, the pain, the grieving of a loved-one, and also how interesting to listen and think about treating a patient who was a joker and a “sunny man”, but turned out to be a sad and rigid man because of his chronic pain, that completely took over both his mind and body.

The four years I spent as a psychiatrist treating people with chronic pain and terminal patients for Palliative Medicine taught me a lot about the interaction of body and mind, but especially about the variations in the “idea” of pain, depending on age, culture and ethnic background, and about how people’s emotions - and humor - can be constricted by pain. This experience marked positively my medical life, having the possibility of getting to know another language, the language of pain.

I should emphasize that all my medical life has been informed and influenced by literary vignettes to deepen my comprehension of illness- in this case, more illness than disease- for example, Hans Castorp in Thomas Mann’s “The Magic Mountain”; Ivan Illich as an example of non-compliance with treatment; Ernest Hemingway himself and his personal history and suicide, which was the topic of my Master’s thesis in my psychiatry postgraduate training. I do believe that literature and culture broaden our horizons in psychiatry: they are not only

Continued page 12

Meet Our New Members

Betina Mariante Cardoso, M.D.

From page 11

interesting in themselves, but are also very important in terms of comprehending our patients as real people, in all their human complexity.

The intersection of languages, points of view, cultures and feelings made me very interested in being present for that unique WPA-TPS symposium on 'culture, humor and psychiatry'.

I should also acknowledge that I am the granddaughter of a writer and researcher in history and folklore, and this background is probably one of the stronger roots of my interest in cultural psychiatry. Throughout my childhood, I used to see my grandfather bent over his papers- his sketchbooks-, and at his typewriter, and I was always very curious about what those papers were about, that would cause him to spend so much of his time absorbed by them. This same curiosity ultimately led me to find and participate in that Saturday morning symposium in Florence, in April.

My mother is a physician and my father is an attorney. My father's uncle, Cyro Martins, was himself a medical doctor, a psychoanalyst and a writer, and, currently, his daughter is the director of a research center for psychoanalysis and literature. Cyro Martins wrote extensively about medical humanism. That theme interests me a lot too, being at the center- in my opinion- of all physician-patient relationships. Accordingly, in August 2009, several colleagues and I planned a Program in Medical Humanities for medical students, residents and physicians, in order to bring all these perspectives together: medicine and cultural competencies for coping and

dealing with and for understanding humanism from a contemporary and global point of view: no idealisms, no utopias, just wondering how cultural, literary and artistic points of view could help us in listening to our patients and understanding their problems more comprehensively and more humanely. And, mainly, we want to encourage study of our inner reflections about our patients, our "counter-transference", which is inherent in every physician-patient relationship. Our objectives are developing courses for medical students, residents, and physicians, and publishing projects by the publishing company I have established.

With this aim in mind, in 2008 I became the head of a small publishing company in Porto Alegre, southern Brazil, Casa Editorial Luminara <http://www.editorialluminara.com> (website under construction), with the purpose of going ahead with the idea of advancing discourse and stimulating research in the Medical Humanities and related issues. Our main objectives are to publish books on the relationships between health issues and culture for the general population, as well as to publish research on Medical Humanities. We want to illustrate how medical students and psychiatry residents can benefit from communication skills training, cultural competence enhancement, literary and clinical vignettes to illustrate illness and suffering, and related subjects.

My profound wish, that one that drives me really, is the idea of initiating a discipline in medical school for this subject matter in Brazil. All this is still a dream. I hope it can come true some day, and I will continue to strive to make the dream a reality.

In pursuit of these dreams, in 2009 I found the

Continued page 13

Meet Our New Members

Betina Mariante Cardoso, M.D.

From page 12

Transcultural Psychiatry Section in WPA, and I found a lot of my long-standing questions being answered, in something akin to the way I found answers while sipping coffee on that rainy Sunday afternoon in Pisa, at Caffè dell'Uszero, reading Pirandello and thinking about “when, where and who” would respond to my wish that psychiatrists would give serious attention to the study of culture, humor and psychiatry.

I first thought about writing my bio-sketch like an anamnesis, but the writing process has nothing to do with “I first thought about...”. I think, truly, the writing process just happens in the process of translating thoughts into words on paper, a rebel in our hands.

Thank you very much, Dr. Wintrob, for creating the opportunity for me to become a member of the Transcultural Psychiatry Section of WPA. It is for me a great honor and pleasure to be part of the life of the Section.

Niall Crumlish, M.D.

I grew up in Dublin, Ireland in the 1970s and 1980s. Dublin in those days was not the most multicultural city in history. Not a melting pot; not exactly New York. No one migrated into Ireland – rather, we left, in our thousands every year, as we had been doing for decades. We trained as nurses in England or worked on the buildings in Australia and the States. The news at Christmas always had a camera crew at the airport, welcoming the

emigrants home for the couple of weeks, but the countdown to the long sad flight home had already begun by the time they reached the airport car park. “When do you head back?” is invariably the first question an Irish person welcomes you with. Serious inward migration only began during the boom – it seemed real at the time; it feels like an illusion now – that lasted from the late nineties till 2008. In one year, 2006, around 100,000 migrants came into Ireland. We had never seen the likes of this, and it was heady. Dublin was transformed.



Twenty years ago I chose a medical career with two Eighties events very much in mind. One was the seeming never-ending recession. With 20% unemployment, I wanted a job I would not lose. (During the boom, this seemed a quaint notion.) The second was Live Aid. I was eleven, and I clearly thought “I want to be a doctor” when I watched the footage from Ethiopia that July. Of course I haven’t lived up to my pre-adolescent aspirations, but those

Continued page 14

Meet Our New Members

Niall Crumlish, M.D.

From page 13

were formative times, and there's time yet.

My first encounter with transcultural psychiatry was in 1996, which was only just after my first encounter with psychiatry of any kind, in the spring of my final year of medical school. That summer, I helped out in a psychiatric clinic in Nyahururu, Kenya; I say 'helped out', but mostly I sat and listened while my clinical officer colleague dispensed words of support – and what little medication he had – to a long line of people two mornings a week.

What I remember from that clinic is that the problems of the people of Nyahururu were essentially no different to those of Dubliners, and this to me is the essence of transcultural psychiatry: it's what we have in common, not the minor details that separate us, that's important. There are exceptions: in Nyahururu we looked after one young army officer who was recovering from a severe episode of mania with grandiose delusions who used to come to the clinic in uniform armed with an automatic weapon. No-one bar me seemed remotely nervous. This, I have a hard time imagining in Ireland.

My psychiatric career proper began in 1999, and it began acquiring some direction in 2003 when I took up a post with Professor Eadbhard O'Callaghan in St. John of God Hospital, Dublin, studying first episode psychosis. In 2005, we established a study of family and schizophrenia in our sister service in Mzuzu, Malawi, and my wife and I moved to Mzuzu in 2006.

It is a little hard to write with any authority on

Malawi, because we were only there for a short time; other than the obvious social and economic differences, probably what struck us most, and what we hope has stayed with us, was the collective nature of Malawian society. The idea of the individual almost does not exist. Everything is about the family, then the neighbor, then the wider community. Your neighbors – countrymen, fellow Africans and beyond – are your brothers and sisters.

Sharon developed an alcohol and drug treatment programme which was built around group education and support. The group called the programme "Titemwane" ("Let us love one another"). Some walked for fifteen kilometers to attend; the group began every session with a prayer, and showed a natural sense of solidarity that made us, as suburban secular Westerners, somewhat envious. Our time in Malawi was a happy and productive time, and we hope that our relationship with Malawi and our many cherished friends there will continue for the rest of our lives.

Our schizophrenia study resulted in a paper in the *British Journal of Psychiatry* called "Insight, psychopathology and global functioning in schizophrenia in urban Malawi". We found that functioning in patients with psychosis correlated with their ability to relabel psychotic symptoms, even after controlling for the severity of symptoms and other aspects of insight. This suggested that symptom-focused psychoeducation might be useful in this population. Insight scores were notably low, which likely reflected participants' attribution of illness and individual symptoms to traditional causes, such as ulowi (bewitchment) or the influence of ancestors.

Continued page 15

Meet Our New Members

Niall Crumlish, M.D.

From page 14

We then reported in *Social Psychiatry and Psychiatric Epidemiology* that the family members of Malawians with schizophrenia experienced a greater burden of care the more they knew about schizophrenia as we (researchers) understood it. (The paper was subtitled ‘A Little Knowledge...’, as in ‘... is a dangerous thing’). This finding surprised us; it led us to question the provision of family education using a Western, biopsychosocial model of illness in a Malawian setting. This remains an open question, which we hope to address in forthcoming publications.

Our research work was, and remains, challenging but rewarding. For one thing, we were for a while the leading psychiatric researchers in central Africa! (Malawian infectious diseases research leads the world, for reasons that are not difficult to understand, but mental health lags a little.) We learned a lot about the practicalities of research in a location with a limited infrastructure, and about studying psychosis in a culture with an understanding of mental illness that we did not automatically share. We were encouraged by the level of interest in our work, including an interview that I was asked to do for the *British Journal of Psychiatry* podcast (<http://www.rcpsych.ac.uk/default.aspx?page=3968>).

On my return to Ireland in summer 2007, Dr. Brendan Kelly, who was in the process of setting up a cultural psychiatry service, told me about a Master’s degree in transcultural mental health care run by Queen Mary, University of London. I took up a place in Autumn 2008. The

MSc has been a great experience, with access to teachers of varied experience and enormously high calibre, like Robert White, Nasir Warfa, Kamaldeep Bhui, and the always challenging and engaging Derek Summerfield.

The MSc also led to an opportunity for further research, and my thesis is a systematic review of treatments for post-traumatic stress disorder among asylum-seekers and refugees. The thesis came directly out of clinical experience working with refugees in Dublin. Although there is essentially a consensus on the treatment of PTSD in the general population, the treatment of refugees presents unique and complex challenges, and there was no clear evidence to guide our care of the people who came to our clinic. My MSc was an attempt to synthesise the evidence.

I found, perhaps inevitably, that there is no simple solution to the challenge of PTSD treatment among refugees, but promising strategies including adaptations of CBT and Frank Neuner’s narrative exposure therapy. The review reinforced, of course, how huge and diverse the refugee population is; no review can really expect to encapsulate the whole population. In the course of preparing the thesis I have come in contact with remarkable researchers who have done immense, often brave, work with some of the most vulnerable people on the planet. My senior training finishes in 2010 and I look forward to being a part of the WPA-TPS as my research and clinical career carries on.

Selected Publications:

1. Crumlish N, Samalani P, Sefasi A, Kinsella A, O’Callaghan E, Chilale H. Insight, psychopathology and global functioning in schizophrenia in urban Malawi. *British Journal of Psychiatry* 2007; 191: 262-3.

Continued page 16

Meet Our New Members

Niall Crumlish, M.D.

From page 15

2. Sefasi A, Crumlish N, Samalani P, Kinsella A, O'Callaghan E, Chilale H. A little knowledge: caregiver burden in schizophrenia in Malawi. *Social Psychiatry and Psychiatric Epidemiology* 2008; 43: 160-4.
3. Crumlish N, Whitty P, Clarke M, Browne S, Kamali M, Gervin M, McTigue O, Kinsella A, Waddington JL, Larkin C, O'Callaghan E. Beyond the critical period: longitudinal study of 8-year outcome in first-episode non-affective psychosis. *British Journal of Psychiatry* 2009; 194: 18-24.

Batja Håkansson, M.D.

Cultural medicine and psychiatry are very natural areas of work for me due to my family background and the way I was raised. I was born in India of an Indian mother and Swedish father. My parents were involved in the independence struggle and they worked against the partition of India along religious lines. In accordance with this I was given my official name after a Muslim family friend and political leader although my mother comes from a Hindu family. When I visited Sweden shortly after World War II my mother and I were categorized as Buddhists by mistake. These, and many other religious/cultural designations and experiences have given me much more pleasure and joy in life than troubles.

Our home – and my hometown Calcutta – was a meeting place and refuge for people from all over the world at that time, the early years of my life. I returned to Sweden for my kindergarten year and after that grew up in a progressive international boarding school, the

Ecole d'Humanité, in Switzerland. The school was the opposite of the “usual” Swiss boarding school as it was a continuation of a pioneering coed school in Germany (Odenwaldschule). The founders and directors, Paul Geheeb and Edith Cassirer Geheeb, had succeeded in bringing out several Jewish teachers and children to Switzerland and other countries when the Nazis took over the school. Some of the Jewish refugees had gone to Israel and returned when I was just beginning school. They brought with them ideals, songs and dances from the “kibbutzim” (collective farming communities) which greatly influenced me. The directors also had deep ties with India and became my protectors. Edith, in the years after I graduated, became a close friend, sharing her wisdom and the cultural heritage of pre-war multicultural Germany.

Several of my schoolmates and friends were “war babies”, with German mothers and – usually



Continued page 17

Meet Our New Members

Batja Håkansson, M.D.

From page 16

unknown – American fathers. Those of Afro-American descent, and I, were often presented as the “international exotic” pupils and this was seen as something to be proud of, so being met with racism outside of school came as rather a shock to many of us. At an early age I decided to do what I could to combat racism and injustice. I had some opportunity to do this as I interrupted the first years of school with frequent travelling, together with my sister and my mother – a follower of Gandhi - in devastated post-war Germany and Austria. We combined Indian music and dance performances with pleas for international understanding and non-violence.

My father had moved to the USA to study anthropology and he sent us books and records based on his experiences with Afro-American and American Indian culture, later on Latin American as he moved on to Cuba. My American school friends brought more of the dances, songs and music from “over there” and singing/guitar playing became an important part of my identity during my teenage years. I was very Americanized as I was enrolled in the American high school section until I had to switch over to the Swiss school system in the last years of school.

After school graduation I came to Sweden and studied comparative literature and education. I thought I had a duty to pass on all that I had received and to contribute to a more tolerant and peaceful world by working with children as a teacher. Coming from a free school I was not prepared for the shock of meeting what I felt

was a destructive approach towards children and education. I turned away from this subject and instead studied sociology, social anthropology, and cultural geography, finishing with a BA in the humanistic and social sciences. Intermittently during my studies, and afterwards, I worked as a social worker, partly in the field of international family law.

It was a one-year trip by car to India that started me thinking of medicine as a possible career. During this trip my late husband and I had to intervene on many occasions where medical and social problems were involved. The injustices and many other sorrows that we saw in the countries we passed through had a very strong impact on my life. But I also experienced again, with awe and joy, the wealth and possibilities of cultural diversity that I had experienced during my school years in Switzerland. I was struck by the generosity, strength and resilience of the many poor and down-trodden people we met and I learned a lot from them about community health and traditional medicine. This contributed to my decision to become a doctor at a rather late age.

I had no intention of choosing psychiatry as a specialty in medicine. On the contrary I belonged to the anti-psychiatry movement for a long time. I worked as a GP in Swedish Lapland and many other parts of the country, getting to know the great social and cultural diversity in even this relatively homogeneous country. While doing my internship in a neurological clinic, for the first time I encountered patients of immigrant background with strange symptoms which turned out to be caused by torture and other traumatic events. I decided that the only place to turn to was the Danish Rigshospital which had opened a centre for victims of

Continued page 18

Meet Our New Members

Batja Håkansson, M.D.

From page 17

torture in Copenhagen. The staff at the Centre were very generous with their advice and this experience led me to work as a visiting consultant when the Swedish Red Cross started a similar centre in Malmo.

My first contact with cultural psychiatry was in connection with a research project concerning existential perspectives on gastrointestinal illness. I had moved to Stockholm where a temporary freeze on new hospital staff positions prevented me from completing my specialization in internal medicine. Since I already had the qualifications – and was close to 50 - I chose psychiatry instead. I continued with research projects, now within the field of psychiatry and addiction, combining existential and cultural interview techniques. Sweden had by now become a multicultural society but was not well prepared for it, which was especially evident within the health care system.

Currently I work part-time as a psychiatric consultant in the St. Goran Pain Clinic, Stockholm, where I recently started a pain management program for patients whose insufficient knowledge of the Swedish language barred them from access to these kind of rehabilitation programs. I also collaborate with a patient organization which gives support and health education to women with immigrant backgrounds. My other part-time work is as a senior physician at the Transcultural Centre, Stockholm County, where we offer clinical training and consultation to health care staff. Our centre is greatly indebted to Professor Laurence Kirmayer, McGill University, who has inspired and

supported our development. I am also indebted to my supportive colleague Henrik Wahlberg, who introduced me to Ron Wintrob, chair of the WPA-Transcultural Psychiatry Section. I immediately felt “at home” and am looking forward to participating in future meetings of the Section and collaboration with other members of the WPA-TPS.

Annie Lau, M.D., FRCPsych

I was born in Brisbane, Australia. My parents, from traditional Chinese families, were refugees from Singapore, having left with the British army with the fall of Singapore to the Japanese in World War II. I grew up in Ipoh, Malaysia, in a multicultural society where all the religious festivals, Muslim, Hindu, Buddhist, and Christian, were celebrated in equal measure. This meant we had school holidays for Christmas, Chinese New Year, Hari Raya Puasa, Thaipusam; all the major religious festivals of the people that made up Malaysian society. School days were spent with children from all the major racial and ethnic groups. Our family lived in a racially mixed neighbourhood, and festivals were marked by families sending food offerings to their neighbors. I grew up expecting a meritocracy, and was head prefect in my last year of school.

I won a Colombo Plan Scholarship to study medicine in Saskatoon, Saskatchewan, Canada, graduated with an MD degree in 1968, and then specialised in Psychiatry. My residency training of four years was divided between university training centres in Kingston and Ottawa, both in Ontario. I was chief resident in my last year, then a teaching fellow, department of psychiatry, University of

Continued page 19

Meet Our New Members

Annie Lau, M.D., FRCPsych

From page 18

Ottawa. I then did further training in child and adolescent psychiatry, and in psychotherapy. What attracted me was the systemic approach, and directly working with families and wider systems.



During this time, I visited the family of one of my patients at a Mohawk reservation near the Great Lakes with members of my team. Kathy, aged 11, told us her family belonged to a subgroup of the Mohawk tribe, but were not fully accepted by the dominant group, and their house had been fire bombed by the neighbors; so as the eldest child in the family she had to stand up for her siblings, and to fight. This led to her being labelled as “conduct disordered” and sent to us, a regional clinical unit

for disturbed young people. The Ontario regional health services leader for Indian Affairs was not happy for us to go to the reservation, but I insisted. We found that what Kathy told us was in fact true. Since then I have tried to challenge prejudicial and stereotyped views of disadvantaged minority groups, which led to an abiding interest in transcultural psychiatry.

In 1978 I moved with my family to the UK. My interest in transcultural family therapy continued to develop, and I started to write and teach in this area. In the 1980’s I joined the Institute of Family Therapy, UK, eventually teaching the transcultural module of their courses, including the MSc at Birkbeck College, University of London. I also developed staff workshops on race and cultural awareness. These included an experiential component in which participants could explore how their assumptions on race and culture, and the impact of those assumptions on their clinical practice, had evolved through developmental experiences in early life. These workshops were held at both national and international conferences, including the first sub-Saharan Connect Family Therapy conference at Harare, Zimbabwe, in 1995.

In 1991, I started to work part time in medical management, with the onset of the health service reforms. I was clinical director of the mental health services, Redbridge Health Care Trust, which covered a population of 250,000. From 2001 to 2005, I was medical director of North East London Mental Health Trust, covering a population close to a million. As medical director I was responsible for setting up the clinical governance (quality assurance) system for the Trust, with direct responsibility for clinical audit and clinical risk. A transcultural expertise and approach helped me to

Continued page 20

Meet Our New Members

Annie Lau, M.D., FRCPsych

From page 19

negotiate between different tribes (specialities, clinical and non-clinical managers), with an awareness of the importance of ritual, acceptable and unacceptable behaviors sanctioned by the group. After stepping down as medical director, I became an associate with the National Clinical Governance Support Team.

In 2002, I commissioned Takashi Sawano, a well-known Japanese landscape designer and my Ikebana teacher of many years, to design and build the Japanese Sanctuary Garden on the grounds of Goodmayes Hospital. I raised all the funds for the construction and maintenance. The garden was opened in 2003 by Julia Neuberger of the Kings Fund. Service users had been involved in helping with the design, construction and maintenance of this garden, which provided a therapeutic and healing environment for staff and users. This was one of my proudest achievements.

I was HMDP (Health Manpower Development Plan) External expert to Singapore in 2002 and have continued to teach at the Institute of Mental Health every time I return to see my family in Singapore for Chinese New Year. I also developed relationships with Anding Hospital in Beijing, and became their UK Psychiatric Advisor in 2000. In 2004 I facilitated a visit to Anding by the Department of Health, and stayed on to conduct a three day family therapy workshop. I have continued to bring Anding clinical staff over to the UK for specialist training, with support from the Department of Health.

I returned to full time clinical work between

2007 and 2008, but also took on a Department of Health project, “Delivering Race Equality” program. Key objectives of this programme were to improve access, experience and outcomes for service users from BME (Black and Minority Ethnic) backgrounds. The Count Me In census of all inpatients across the country had shown consistently, over a four year period, poor access, and experience of BME mental health service users, with Black Afro Caribbean and mixed race seven to eight times more likely to be admitted to hospital under coercion (Mental Health Act 1983) and to receive more restrictive treatment. I suggested that we could look at progress, and promote change, at the beginning of the care pathway, and also support improving outcomes by linking up with the new education strategy on providing access to further education for people with disabilities. This was accepted by both the Department of Health and the Education Department, as a joint strategic project. The report was produced in September 2008, and is now a springboard for a national project looking at regional pairings of early intervention teams and further education colleges. The results show good access by BME service users to early intervention teams, also good access to further education and training where the clinical team has developed a good relationship with the education provider. So change is possible. I was asked to talk about this at a high level cross government departmental meeting with the Learning and Skills Council patron, Princess Anne, and the project has also been presented at various international forums, including WPA.

From May this year, I took on a new role, as clinical advisor at the Parliamentary and Health Service Ombudsman’s Office. Here the task is to work with lay assessors and investigators to

Continued page 21

Meet Our New Members

Annie Lau, M.D., FRCPsych

From page 20

review complaints that have not been resolved via Trusts' formal Complaints route, and identify where relevant, individual and systemic failures, and unremedied injustice. My clinical risk background has been very useful in this regard.

I will finish with a story I have found useful in teaching in various settings. This illustrates how poor cultural competencies in several clinical teams led to inadequate service provision, and to an avoidable suicide.

A man in his 40's presented to his GP with depressive symptoms and suicidal ideas. He came originally from Zimbabwe. He had been a boy soldier in the civil war, and had done horrific things. He asked to see a traditional healer. The GP did not know what to do with him except send him to accident and emergency services at the local hospital.

Here he was seen by a junior doctor who felt he was a suicide risk. There were no beds in his catchment area so he was sent to a unit in another borough. He repeated his history, and said he wanted to see a traditional healer. Again the unit did not get him what he wanted. After a week they discharged him as he did not have a treatable mental illness. They referred him to his area community mental health team, where the case was not assigned for two weeks.

In those two weeks he became more acutely depressed. He stabbed himself twice in the chest and suffered a pneumothorax. He was then admitted to the local hospital where they

gave him one-to-one nursing. The liaison psychiatry team was concerned about him and recommended admission to an acute psychiatric unit upon discharge from the medical assessment ward.

He was discharged over a weekend and seen by a junior doctor on her first exposure to psychiatry. By this time the patient denied suicidal feelings and said the stabbing incident was an accident. The junior doctor admitted him for consultant review early the next week, and 15 minute observations were prescribed. The next person who saw him was a locum consultant who also continued the 15 minute observations. Two days later, the patient walked into the path of a train, and was killed.

I was a member of the internal inquiry panel, and was haunted by this case. Sometime later, I met a pastor from Zimbabwe at a conference, and told him the story. I asked what a traditional healer could have done; or what the patient would have expected from a traditional healer. The reply was; the patient knew, because of all the awful things he did as a boy soldier that he was cut off from his ancestral spirits. In other words according to his belief system he was cursed. As a result he could not have a good death, his family could not rely on the ancestral spirits' protection and blessing. The task of the traditional healer would have been to reconcile him to his ancestors. So the effective treatment of his depression would have needed to include this key dimension of his belief system.

Continued page 22

Meet Our New Members

Marco Scarpinati Rosso, M.D.

From page 21

When Ron asked me to contribute some short biographical notes to this website my first inclination was to decline. As a pretext I could use the lack of time because of my clinical duties and my research project but, basically, the fact is that I do not like to talk about myself. However, driven by curiosity, I decided to take a look at the TPS Newsletter and to read some stories written by colleagues and friends. I was really impressed by the generosity and sincerity they introduced in their own narrations dealing with very personal issues. Moreover, I felt that I share feelings and experiences with a lot of them. So, overcoming my shyness, I decided to write something, even if short.

I was born and raised in Rome. My father, a gynecologist, came from a family of doctors and my mother, of French background, from a family with a long heritage of military officers. Her father was in the diplomatic service, so they travelled a lot. I am still convinced that the fact that she could speak French and Arabic played a big role in my current professional interests. I attended the Classic Lyceum - secondary school with a lot of Latin, ancient Greek and philosophy courses – and then the medical school at the “La Sapienza” University in Rome.

I must confess that I did almost anything to avoid becoming a psychiatrist, even if I was really attracted by this discipline from the beginning of medical school. I thought it was very difficult clinical work, with poor treatment outcomes and a high degree of stigma associated with the field. So, to make my life easier, I specialized in neurosurgery; and then I joined

the army, becoming a professional medical officer. In this way I could make an effective synthesis of my family’s traditions in both medicine and military service.

But as always happens, it is not you who chooses psychiatry, but rather it is psychiatry that chooses you, and nothing can prevent it when you receive the call. In my case, I became a psychiatrist – and at the same time, a cultural psychiatrist – because of a very concrete cause: war.



Although my primary post was the military hospital in Rome, I have been deployed several times abroad, in different conflict areas in peace-keeping and peace-enforcement

Continued page 23

Meet Our New Members

Marco Scarpinati Rosso, M.D.

From page 22

operations. During these missions, trauma was a constant aspect of my daily clinical work with the military personnel and with the civilian population that we protected and took care of. During the Kosovo crisis I was deployed as observer for the OSCE (Organization for Security and Cooperation in Europe) in the capital, Pristine. Before the NATO bombing of Serbia, our unit moved to Macedonia to organize and monitor the refugee camps near the borders. During this mission I faced the complex and grave burden of war on the population, and the impact that violent ethnic discrimination, displacement and loss has on peoples' mental health.

This experience has influenced me in several ways. From the clinical point of view, I felt a need to approach the complex phenomenon of trauma from a different and more global perspective, scrutinizing the tight paradigm of PTSD as we use it today. From a broader perspective, I understood that the current models of intervention in relief activities are not effective. Moreover, I thought about the big challenge societies and health services face as a consequence of globalization and the need for a cultural perspective in psychiatry. Thus, I decided to become a cultural psychiatrist and to increase my knowledge and skills through research. So, I took my specialty training in psychiatry in Rome – thereby changing my clinical perspective from neurotraumatology to psychotraumatology. I resigned from the army and I decided to move anywhere I could realize my clinical and research objectives as a cultural psychiatrist.

Currently, I am a Ph.D. candidate at the Clinical Neuroscience Department of Karolinska Institute in Stockholm. I work part time on my thesis about the clinical application of the Cultural Formulation, and part time as a senior consultant psychiatrist at the Transcultural Centre in Stockholm, together with my friend Henrik Wahlberg, who introduced me to the Transcultural Psychiatry Section of WPA.

My research interests are in cross-cultural psychopathology, psychotraumatology and the interactions between the cultural mind-sets of patients on one hand, and the health services system on the other.

After all these years of clinical practice, I must admit that I still do not believe that cultural psychiatry is radically different from usual psychiatry. The needs of the patients are almost the same; to be understood and respected.

But what is really important and unique is that cross-cultural psychiatry can contribute to the reflections on psychiatry itself, about its asymmetrical power relationships between patients and their families, and the health services personnel who provide treatment for them; as well as how to avoid the stereotyping of people as patients. These things are really needed in all aspects of contemporary psychiatric practice.

Anne-Marie Ulman, M.D.

I am a French-born Israeli, of Jewish Polish origin. This in itself synthesizes quite well the multiple facets of my identity.

My parents were adolescents when World War

Continued page 23

Meet Our New Members

Anne-Marie Ulman, M.D.

From page 23

It exploded on the scene. They lived in Galicia, Poland, the “cradle” of a proud Polish nation. It wasn’t easy to be a Jew in a country in search of its own identity. My parents are Holocaust survivors, the only survivors from their nuclear families. Destiny and historical circumstances brought them together in France where they met after the war ended.

I consider my first name to be an example of their endless quandary around identity: Anne-Marie. What could sound more French than this name, though its true meaning was my mother’s desire to commemorate her young sister Mari-sia and her beautiful aunt, Anna, and probably was also intended to commit me deeply to the duty of remembrance.

I completed my school years at the very selective “Ecole Alsacienne”. But the passionate discussions we had during French literature, philosophy and history classes about basic concepts like democracy, revolution, humanism etc, could not compensate for my feeling of being an alien in France; as the daughter of Holocaust survivors in the midst of children from left-wing intellectual bourgeois French families.

Medical school, with the conservatism characterizing this very specific milieu didn’t diminish this feeling of being a stranger in my own country. As a matter of fact the question was not whether I should move to Israel but rather when I should move there. I concluded that the best timing was at the end of medical school and before starting residency training in psychiatry.



Israel has been an important part of my life since the very beginning. My parents and I used to spend summer holidays with relatives who had also survived World War II and had moved to the new country. Every summer we traveled for vacation in a “moshav” located in the very center of Israel. At that time, moshav was a type of cooperative agricultural community of individually managed farms. I believe in the importance of pre-verbal period experiences and the memories connected to my experiences living in the “moshav” are particularly dear to me.

Growing up I could understand that everybody came from somewhere and had his/her own history; that Judaism was not something to hide or explain, but rather dictated the rhythm of everyday life. Here I could feel part of something positive and alive, so much more in accordance with the multiple aspects of my identity, and so

Continued page 25

Meet Our New Members

Anne-Marie Ulman, M.D.

From page 24

different from the narrative of my school friends. After psychiatric residency, I worked for nine years as a senior psychiatrist in a locked ward. Five years ago I moved to a rehabilitation ward. For the past four years I have been involved in cultural psychiatry activities.

As strange as it may seem, cultural psychiatry is not a highly developed field in Israel. Some psychiatrists show interest in specific communities, but the general attitude is to refer to DSM, as it is applicable to everybody irrespective of cultural background. Concepts of culture as a significant influence on the clinical picture, as a factor contributing to the therapeutic attitude and as a possible therapeutic gap between therapist and patient are not widely considered in Israeli psychiatric practice. Accordingly, I felt ineffective with certain sub-groups of the population. But without guidance my didactic learning was not translated into effective clinical practice.

The turning point in my career was my meeting with Tobie Nathan, the French psychologist and psychoanalyst and founder of the Ethnopsychiatric School, while he was in Israel undertaking a diplomatic function. His knowledge about African populations and therapeutic practice in the context of migration was of great help in my encounters with Ethiopian immigrants to Israel, a group of the Israeli mosaic population for whom “acculturation stress” and “culture shock” are the most intense of any sub-group in the country. With his supervision I organized a cultural psychiatry consultation service where I meet with mostly patients of Ethiopian origin.

Since then I have been developing progressively the issue of cultural psychiatry in Israel by taking part in diverse projects and activities, mainly research and teaching. I joined the Euromed-Network association as a founding member and Steering Committee member for Israel, and I am a member of the cultural psychiatry section of the European Psychiatric Association.

My purpose in joining the WPA-TPS is to create new contacts that will help me to develop my activity in the field. After failure of the “melting-pot policy”, decision makers in the field of health policy in Israel have become more open to concepts like cultural competence and culturally sensitive medicine. Therefore I wish to encourage and further this process.

My priority goal is education. It’s time to develop educational programs that will invoke medical student sensitivity and develop psychiatric resident skills relevant to culturally competent clinical practice. As a start, this year I will be delivering a lecture about culture and psychiatry in the framework of psychiatric resident post-graduate studies.

Research is the second pillar of my interest. I am involved in a pilot study on suicide prevention, which is an acute problem among people of Ethiopian origin in Israel, a study funded by the Israel National Institute for Health Policy Study, exploring the place of cultural factors in, diagnosis treatment and prevention of suicidal behaviors.



Dr. Kinzie's Book Notes

J. David Kinzie, M.D.
Book Review Editor

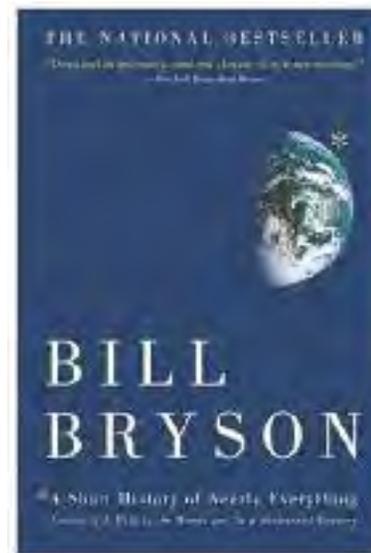


A SHORT HISTORY OF NEARLY EVERYTHING

by Bill Bryson
(2003)
Broadway Books

BRYSON'S HISTORY is a best seller and an easy-read that nearly lives up to the ambitious promise of its title. The author admits that before he started writing, he didn't know the difference between a proton and a protein, but through diligent research, he has written a remarkably clear (though over-simplified) history ranging from the Big Bang through the evolution of life on earth and finally to the creation of mankind. It is a prodigious undertaking with chapters on the size of the earth, Einstein's insights, the nature of life, and man's place in nature. Rather than trace a time line of events, Bryson takes a more entertaining approach and describes major historical figures and their personality quirks. These descriptions are gossipy and somewhat voyeuristic. We learn that Newton was odd and joyless, Dr. Parkinson (of Parkinson's Disease) was a provocative socialist, and Darwin was a depressive personality with

psychosomatic problems. Lord Kelvin estimated the age of the earth at 400 million years, Cope and Marsh became bitter rivals over British paleontology; Lavoisier, the father of modern chemistry, was guillotined in the French Revolution; while Madame Curie had an adulterous affair with a married physicist; Einstein refused to accept plate tectonics, and the scientific community ignored the impact of meteors on the earth. Barton is barely mentioned for his pioneering underwater explorations, and in spite of the popularity of Gould's book on the Burgess shale fossils, there remains much disagreement about its significance. More recently, Watson and Crick received a Nobel Prize for their discovery of the double helix formation of DNA, but the contributions of Rosalind Franklin with x-ray crystallography have been unacknowledged.



Besides complex personality problems, the scientific community has had many bitter disagreements that usually involve large egos and make for interesting reading. With all the jealous squabbling, it's difficult to see how any progress was made. But it was, including progress in understanding the development of our

Continued page 27

Book Notes

From page 26

own species from the Pleistocene to Homo Sapiens. As for the future, according to Bryson, it is bleak. Ice ages come and go, and so far we have been lucky to escape a recurrence. As this “history” indicates, we (life on earth) are lucky to here at this time on this planet on which everything is possible. We are also lucky that “we enjoy the privilege of existence but also the ability to enjoy it.”

AN END TO SUFFERING: THE BUDDHA IN THE WORLD

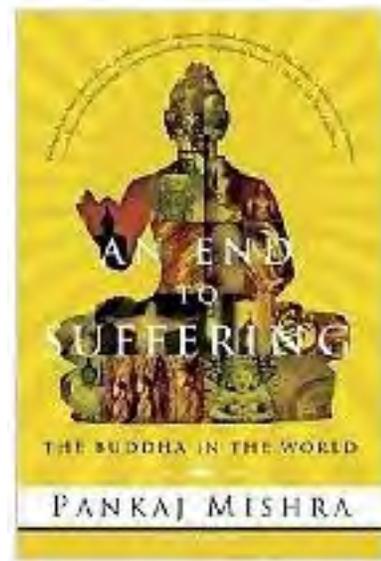
by Pankaj Mishra
(2004)

Farrar, Strauss and Giroux

PANKAJ MISHRA was born in North India in 1969, and published a highly acclaimed book of fiction, *The Romantics*. His new book, *An End to Suffering*, is, however, a personal and historical exploration of Buddha and Buddhism. It is both odd and appropriate that an Indian should “discover” Buddhism. Buddha, like Mishra, lived in Northern India, but during the 6th Century, B.C. Today there are nearly no Buddhists in India, although the religion has been successfully transplanted to Tibet, China, Japan, Indochina, and Sri Lanka. The many new forms of Buddhism now practiced would probably be unrecognizable to the original Buddha. Just as Jesus would probably not recognize the many modern versions of Christianity.

An End to Suffering (the title contrasts with the Christian goal of an end to sin) is both Mishra’s historical analysis of Buddha’s place in the 6th

Century B.C. world, and also a personal account of his contemporary experience of Buddhism. In 1992 Mishra moved to an isolated Himalayan village to read and reflect and eventually to travel in an effort to better understand Buddha’s message. His scholarship paid off and he is able to accurately describe “the invention of Buddhism” by 19th and 20th century writers and archeologists, as well as the 6th century B.C. world of Northern India with its small kingdoms and a pantheon of Hindu gods. This was an era of a countercultural conflict with the overthrow of the Brahman priests and the emergence of radical thinkers. It was hard to be a Hindu, and as Nietzsche suggested, it was a time like 19th century Europe when it became hard to be a Christian. Indeed, Mishra draws upon his scholarly knowledge of European literature as well as the history of Indian thought, and he finds parallels to both in Buddha’s time.



There are probably better explanations of Buddha’s life (and legends) in other books (see Karen Armstrong’s book on Buddha) but the author’s knowledge and experience in India gives him a unique perspective on Buddha’s enlightenment, his Four Noble Truths

Continued page 28

Book Notes

From page 27

and his psychological view of the mind.

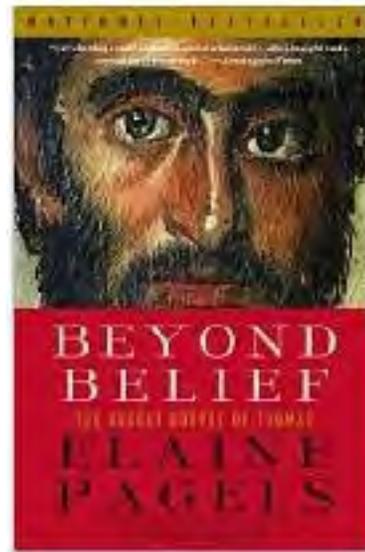
Even more perceptive are Mishra's comments on London and America, and the growing Buddhist movement in these countries. It is as though the foreigner could understand another country better than its own residents. Toward the end of Buddha's life, a series of bloody battles raged across Northern India - a situation which the author compares to the current Indian-Pakistani battle over Kashmir, and indeed the entire bloody 20th century.

How Buddha would have reacted to contemporary violence is, of course, unknown. The Buddha's view of the self, not as distinct and unchanging, but as part of a causal process in the world could help to diminish self-centered destructive emotions, such as hatred and anger. Buddhist philosophy had a great influence on Ghandi and the nonviolent resistance and the growing popularity of an "engaged Buddhism" in the West might even be a surprise to Buddha himself. As the author finishes the book after the Twin Towers attacks and amid escalating violence, the Buddha's moral and spiritual ideology no longer seem something out of the past but a necessary therapy for current times.

**BEYOND BELIEF:
THE SECRET GOSPEL OF THOMAS**
by Elaine Pagels
(2003)
Random House

CHRISTIANITY, and indeed all religions, come and go in the public awareness as times change.

Currently religion is once again on the public's mind and in the popular press. Mel Gibson's movie, *The Passion of Christ*, coincides with public displays of religious fervor by politicians. Indeed, antagonists debating such contentious issues as homosexuality, abortion, prayer in school, and the inclusion of the words "under God" in the Pledge of Allegiance often use religious (and sometimes Biblical) arguments to bolster their positions. One may think that the diversity and even hostility in current Christian thought represents a new and dangerous phenomenon. However, these books by Pagels and Ehrman clearly demonstrate that such disagreement and diversity have accompanied Christianity since its inception, and the historical appearance of consensus is only an illusion.



Pagels, a professor of religion at Princeton, is an influential religious historian. She writes eloquently contrasting the "secret" Gospel of Thomas with the Gospel of John. The Gospel of Thomas was discovered in 1945 in Upper Egypt in a cache of early Christian writings. The manuscript includes sayings and dialogues that were attributed to Jesus but never became

Continued page 29

Book Notes

From page 28

part of the New Testament and were deemed heretical by some early Christians. The author of the Gospel of John, like Thomas, is unknown, but its tone and content differ significantly from the writings of Matthew, Mark, and Luke. Pagels' analysis leads her to believe that John was written to discredit Thomas. The primary difference between the two gospels is that Thomas believed we all have the inner capacity to be like Jesus, while John maintained that Jesus was more than unique, not a man but God Himself. For John, only through belief in Jesus could we find divine truth. This view prevailed and became a fundamental article of faith in orthodox Christianity. But modern scholarship has shown that the writings of Thomas and other "secret" writings show wide variations in early Christian perspectives. The view of John's gospel - Jesus as God - became part of the Nicene Creed, and other interpretations by Thomas (and, to some extent, the other three gospels) were suppressed in ... well, an "unchristian" manner.

The only distraction from this easy-to-read book is that the Gospel of Thomas is not presented directly, and the reader does not get the opportunity to interpret its message for him - or herself.

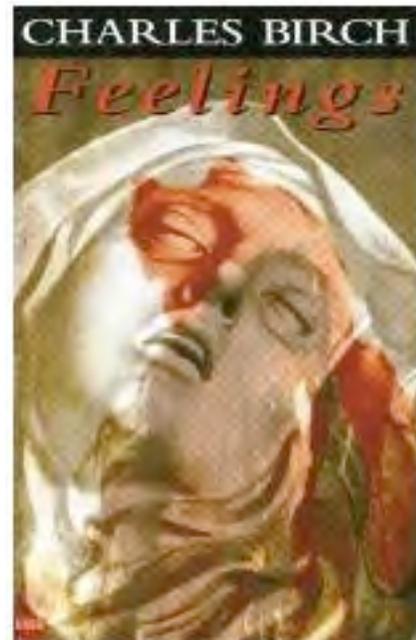
FEELINGS

by Charles Birch
(1995)

University of New South Wales, Sidney

WHEN WE WERE RESIDENTS, my colleagues and I once complained to a professor that we weren't learning as many "facts" as the

residents in internal medicine. Our professor replied that what we needed to learn more about was feelings. He was correct. Self-awareness of our internal state is essential for psychiatrists. It's our business to study feelings and subjectivity and, by astute observation, learn to understand and make accurate assessments about how and what our patients feel. Feelings are the "stuff of human experience" and should be discussed more often during residency.



Charles Birch, author of *Feelings*, is an emeritus professor of biology at the University of Sydney and winner of the 1990 Templeton Prize for his scientific contribution to "progress in religion." In this book, he reflects on both of his interests, biology and religion. It starts with a straightforward discussion of human feelings and the importance, if not primacy, of the internal state, i.e., subjectivity. Birch also describes the feelings of animals, providing data that animals have some type of self-awareness based on their complex nervous systems and similarity to humans, and including evidence that chimpanzees possess self-consciousness. He moves on to

Continued page 30

Book Notes

From page 29

the nature of nature and a discussion of what is the mind. He recognizes that the predominant paradigm in this area is the concept of emergence, i.e. mind evolved with the development of a more complex central nervous system. Birch's ideas become less conventional when he considers panexperientialism, the concept that the experience of subjective feelings exists in some form in all individual entities, and all matter is related to all other matter. Therefore, human experience is a higher level of the exemplification of reality in general, i.e., "the stuff of the world is mind stuff." This is indeed a unique if not revolutionary idea.

Birch feels that mind cannot arise from no mind and that the difference between humans and other entities is only in the degree of a general property of "stuff." He digresses to the topic of artificial intelligence and maintains that the thinking machines can never have feelings, because they are an aggregate of parts rather than a unified whole acting together. His last chapter is even more speculative dealing with God's feelings. He states that the universal existence of subjectivity in individual states requires the existence of a common mind, i.e. God, and is a natural rather than a supernatural phenomenon. The feeling of compassion is man's response to God's feeling for the world. At this point, it is difficult if not impossible for Birch to become anthropomorphic, and this seems a belief, beyond any evidence presented. Although Birch's ideas are attractive and I generally support his views, I cannot see the supporting evidence in his discussion of the universal existence of subjectivity. Although the book is brief, 132 well-referenced pages, it offers a great deal of information varying from the straight-forward

discussion of the biological basis of subjectivity in humans to a more speculative subjectivity throughout the universe. Even though Birch's notion of universal subjectivity and the common mind does not convince me, it is a brave and daring proposition.



Recent Advances in Cultural Psychiatry Research in Israel

Robert Kohn, MD
Brown University

Two of our new TPS members are from Israel, highlighting that Israel is a potential laboratory for cultural psychiatry research. I myself have been privileged for over the past 20 years to have a direct role in helping understand the mental health needs of the country by conducting epidemiological research there. Much of that research has had a cultural psychiatric focus.

In the past year we examined Soviet immigration and mental health and found higher rates of psychological distress and common mental disorders compared to non-immigrant controls [1]. This finding is in contrast to those in the

Continued page 31

Recent Advances in Cultural Psychiatry Research in Israel

From page 30

United States and other countries where immigrants appear to have lower rates of depression and anxiety disorders. We hypothesized that this difference was due to the nonselective migration policy of Israel in contrast to that of other nations.

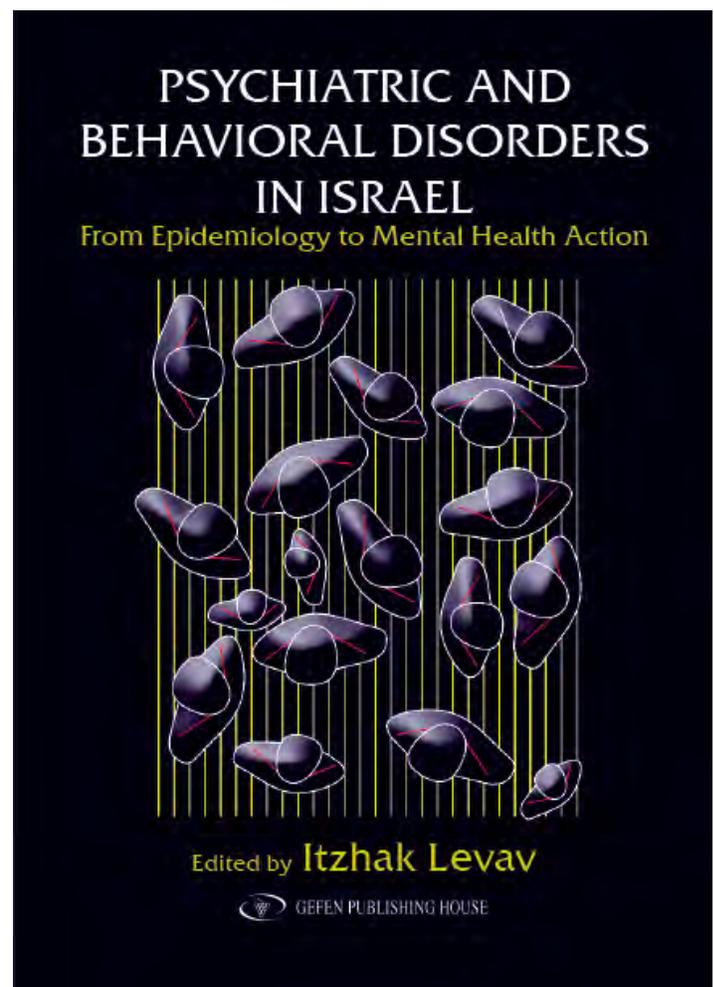
We looked at the effects of religious observance on exposure to terrorism among Jewish settlers in Gaza, prior to the evacuation, and the West Bank [2]. We showed that the higher the religiosity the lower was the risk of demoralization.

Several studies were conducted on Holocaust survivors. The first was a national survey of elderly Jews of which 896 were Holocaust survivors. This study found a higher rate of psychological distress (demoralization) among survivors compared to controls, but the effect disappeared when education and number of chronic illness were included in a multivariate model, both of which may be direct factors of the Holocaust [3]. Sleep disturbance thought to be a residual symptom of post-traumatic stress was still present at high rates. These findings were highlighted most recently in a publication in the British Journal of Psychiatry. In this study based on the Israel World Mental Health Survey we conducted the first ever study of Holocaust survivors examining the presence of psychiatric disorders, not just demoralization. The Holocaust survivors had higher rates of anxiety disorders than controls, but not post-traumatic stress disorder or major depression [4]. In addition, like the earlier study excessive sleep disturbance was found.

In addition, this same survey examined

psychopathology among children of Holocaust survivors [5]. As in an earlier study, adult excess psychopathology was not noted in this population contrary to many clinical reports [6].

An excellent review of these issues and other aspects relevant to the mental health of Israelis can be found in the recently published text by Itzhak Levav, *Psychiatric and Behavioral Disorders in Israel*. (<http://www.gefenpublishing.com/product.asp?productid=727>) [7].



I myself am looking forward to continuing to participate in research on cultural issues in Israel. We are currently conducting additional studies on immigration, on Holocaust survivors, and the role of religiosity.

Continued page 32

Recent Advances in Cultural Psychiatry Research in Israel

Future International Conferences in Cultural Psychiatry, Sponsored and Co-Sponsored by TPS

From page 31

REFERENCES

1. Mirsky J, Kohn R, Levav I, Grinshpoon A, Ponzovsky AM. Psychological distress and common mental disorders among immigrants: results from the Israeli-based component of the World Mental Health Survey. *Journal of Clinical Psychiatry* 69:11; 1715-1720, 2008
2. Levav I, Kohn R, Billig M. The protective effect of religiosity under terrorism. *Psychiatry: Interpersonal and Biological Processes* 71:1; 46-58, 2008
3. Shemesh AA, Kohn R, Radomislensky I, Brodsky J, Levav I. Emotional distress and other health-related dimensions among elderly survivors of the Shoa living in the community. *Israel Journal of Psychiatry and Related Sciences* 45:4; 230-238, 2008
4. Sharon A, Levav I, Brodsky J, Shemesh AA, Kohn R. Psychiatric disorders and other health dimensions among Holocaust survivors 6 decades later. *British Journal of Psychiatry* 195:4; 331-335, 2009
5. Levav I, Levinson D, Radomislensky I, Shemesh AA, Kohn R. Psychopathology and other health dimensions among the offspring of Holocaust survivors: results from the Israel National Health Survey. *Israel Journal of Psychiatry* 44:2; 152-157, 2007
6. Levav I, Kohn R, Schwartz S. The psychiatric after-effect of the Holocaust on the second generation. *Psychological Medicine* 28:4; 755-760, 1998
7. Levav I (ed.). *Psychiatric and Behavioral Disorders in Israel*. Jerusalem, Israel: Geffen Publishing House, 2009



There is a very full agenda of international conferences on cultural psychiatry being sponsored and co-sponsored by WPA-TPS in 2010 and 2011.

In 2010:

International Conference on Transcultural Psychiatry: Cultural Diversity, Social Change and Mental Health in China; Shanghai, China; April 18 – 20

International Conference on Transcultural Psychiatry: Migration, Next Generations and the Future of Psychiatry; Amsterdam, The Netherlands; June 13 – 16

1st International Conference on Cultural Psychiatry in Southern Africa; Durban, South Africa; September 26 – 29

1st International Conference on Cultural Psychiatry in the Spanish-speaking World; Barcelona, Spain; October 30 – November 1

4th International Conference on Cultural Psychiatry in the German-speaking World; Dusseldorf, Germany; December 9 – 11

In 2011:

1st International Conference on Cultural Psychiatry in the French-speaking World; Paris, France; April 16 – 19



International Conference on Transcultural Psychiatry: Cultural Diversity, Social Change and Mental Health in China

Dates: 18-20 April 2010

Conference Venue:

Purple Mountain Hotel. Located in the Lujiazui Area of Pudong District, Shanghai
<http://www.shzjshotel.cn>

Sponsors:

The World Psychiatric Association Section of Cross-cultural
The Chinese Psychiatric Association

Local organizer:

The Oriental Hospital of Shanghai

Co-organizers:

The Medicine Institute of Tongji University
The Mental Health Center of Shanghai Jiaotong University
The Hong Kong Polytechnic University

Fee (Including the Registration fee and material fee):

Before January 10th, 2010, registration fee is US\$400

After January 10th, 2010, registration fee is US\$600

Conference Organizing Office:

Address: Post-box No. 244, Tongji University
Siping Road No.1239,
200092 Shanghai, China
Telephone: +86 21 65988874
Fax: +86 21 65988874
E-mail: psychechina2010@gmail.com
website: <http://www.psychechina2010.org.cn>

Please submit your papers on our website.

Theme:

With the continuous growing need for mental health across the whole world, cultural psychiatry is moving from the edge toward the mainstream, from a Westerner's adventure for adventures into necessary knowledge and skills for every clinic practices of different countries, from a small number of experts' exploring the alien cultures into deep reflection of the mainstream culture on mental health issues. At the same time, with a growing international influence of China playing, the Chinese culture and mental health practice are gradually becoming the focus of attention in the academic. Therefore, the World Psychiatric Association for Cross-Cultural Section (WPA-TPS) decided to cooperate with the Chinese Psychiatric Association (national psychology and psychiatry group), in cooperation in April 2010 18-21 held in Shanghai, China Pudong, China as the theme of "International Cultural Psychiatry Conference: China's cultural diversity and social change "(International Conference on Transcultural Psychiatry: Cultural Diversity, Social Change and Mental Health in China).

The main content will conclude topics from medicine and mental health, psychology, sociology, cultural anthropology fields which are related to mental health. Many world-renowned experts and famous Chinese experts confirmed their attendance, keynote speeches, or invited speech. This meeting is the first great time which brings together psychiatrists and other related disciplines fellow into depth exchange. We sincerely invite professionals from around the world (doctors, psychologists, sociologists, social workers, cultural anthropology and ethnic studies, nursing, etc.) to join us, and submit your papers!

Our Congress date is only 10 days away from the Expo event!

International Conference on Transcultural Psychiatry: Cultural Diversity, Social Change and Mental Health in China

April 18-20, 2010, Shanghai, China



As the international society has been paying more and more attention to Chinese rapid development, the Chinese culture and mental health practice are becoming the focus of attention in the academic fields. The Transcultural Psychiatry Section of World Psychiatry Association for (WPA-TPS) and the Chinese Psychiatry Association will hold "International Conference on Transcultural Psychiatry: Cultural Diversity, Social Change and Mental Health in China" from 18-20, 2010.

The main contents will include topics related to psychiatry and mental health, psychology, sociology, cultural anthropology and so on. Many world-renowned experts and famous Chinese experts have confirmed their attendance as key-note speakers and invited speakers. This meeting is the first time in China to bring mental health professionals and other related disciplines of social sciences together for in-depth exchange. We sincerely invite colleagues who are interested in these issues from around the world to join us, especially physicians, psychologists, social workers, ethnologists, nurses. You are also welcomed to submit your papers for symposia and posters presentation!

Besides the academic attraction, we are happy to offer you a great gift – WORLD EXPO 2010, Shanghai!

Our Conference time is just within the test-running period of the EXPO, and the official opening will be May 1st, 2010. The conference venue is close to the Expo Area.

Sponsors: Transcultural psychiatry Section of The World Psychiatric Association, The Chinese Psychiatry Association

Local Organizer: Shanghai East Hospital Affiliated to Tongji University

Co-Organizers: Shanghai Mental Health Center, Hong Kong Polytechnic University

Honorary Chairperson: Mingyuan Zhang (China), Wen-shing Tseng (USA), Jingping Zhao (China)

Chairpersons: Ronald Wintrob (USA), Zhongmin Liu (China), Xudong Zhao (China)

Chairpersonss of Academic Committee:

Ronald Wintrob (USA) Zeping Xiao (China) Angelina W.K. Yuen Tsang (HongKong, China)

Junior Schedule

Year2010	8:30 - 10:10		10:30 - 12:10		13:30 - 15:10		15:30 - 17:10		18:00 - 20:30
4.17	Registration								
4.18	Opening ceremony; Key-note speeches *2	Teabreak	Invited speeches *3	lunch	Symposiums *4*4	Tea break	Symposiums *4*4	Banquet;Cultural program	
4.19	Invited speeches *3	Tea break	Symposiums *4*4	lunch	Invited speeches *4person	Tea break	Invited speeches *4*4		
4.20	Symposiums *4*4	Tea break	Symposiums *4*4	lunch	Invited speeches *4 Closing ceremony	Tea break	Invited speeches *2;	Dinner on Huangpu River	

Language:

English and Chinese

The key-note speeches at the opening ceremony:

1. Chinese Culture and Mental Health. Professor Desen Yang, Central South University.
2. The Developmental Trend of World's Cultural Psychiatry. Professor Wen-shing Tseng, University of Hawaii.

Themes speeches, Symposia and posters

1. Development of world's cultural psychiatry (by international experts).
2. Chinese culture and mental health.
3. Influence of social changes on characters of Chinese.
4. Family and mental health.
5. Chinese collectivism and social behavior.
6. Acculturative stress of Chinese overseas.
7. Dialogue between Traditional Chinese Medicine (TCM) and Western psychology.
8. Psychotherapeutic concepts and methods in TCM.
9. Folk healing in contemporary society.
10. Cultural affinity and cultural barriers of psychiatry in China.
11. Cultural affinity and cultural barriers of psychotherapy in China.
12. Psychotherapy with Chinese characteristics.
13. Strategies of mental health promotion -- the role of social workers.
14. Epidemiological data reflecting changes of disease spectrum in China.
15. Globalization, urbanization and mental health.
16. Changes of the rural areas and mental health.
17. Researches on mental health of nationalities minorities.
18. Researches of migrants' mental health.
19. Chinese mental health from the global perspective.
20. Psychological crisis and suicide.
21. Social cultural change and psychopathology.
22. Unique psychopathological issues of Chinese.
23. "Stigma" on psychiatric patients and related cultural factors.
24. Culture, gender and mental health.
25. Aging and mental health.
26. Mental health of adolescents in changing society.
27. Cultural factors in psychological disaster relief works.
28. Shamanism, Shaman in ethnic groups in China.
29. Folk beliefs, witch phenomenon from mental health perspective.
30. Substance abuse and social cultural change.
31. Cultural adaptation and mental health of the foreigners living in China.
32. Transcultural marriage, intermarriage and mental health.
33. Culture and neurosciences.
34. Cultural factors influencing drug therapy.
35. Others



Conference Venue:

Purple Mountain Hotel (5-Star hotel), located in the Lujiazui Area of Pudong District, Shanghai.
<http://www.shzjshotel.cn>

Accommodation:

Hotels of different categories near conference venue are available upon reservation on time. Please contact us for detailed information.

Fees: US\$ 400 (before Jan. 31st, 2010), US\$ 600 (after Jan. 31st, 2010)

Conference Organizing office:

Address: Conference Organizing office, Post-box No. 244, Tongji University Siping Road No. 1239,
200092 Shanghai, China

Telephone: +86 21 65988874;

Fax: +86 21 65988874;

e-mail: psychechina2010@hotmail.com

website: www.psychechina2010.org.cn



Please find more details on our website!

Paper call:

Please submit your papers on our website.

**International Conference on
Transcultural Psychiatry
13 - 16 June, 2010
Amsterdam, the Netherlands**

You are all invited to attend and contribute to the International Conference on Transcultural Psychiatry, 13 - 16 June, 2010 Amsterdam, the Netherlands.

For all information, submission of abstracts and registration: see the congress website: <http://www.tp2010.org>

Theme:

“Migration, next generations and the future of psychiatry”.

Organizing bodies:

Netherlands Association of Psychiatry-section Transcultural Psychiatry, in collaboration with the World Psychiatric Association-Transcultural Psychiatry Section.

Co-sponsored by the Nordic Network for Cultural Psychology and Psychiatry

Main conference subthemes:

1) Next generation migrants, 2) Illness and disorder, 3) International mental health, 4) Diagnosis and therapy, 5) Research and development, 6) Situational stressors.

Introduction to the theme:

The world is changing rapidly. More than ever since World War II people are on the move, mainly driven by poverty or violence. In order to survive migrants are challenged to participate in new environments and find their way in multiple social worlds. Not only geographical borders are crossed, but also virtual ones by surfing the internet and symbolic ones by culture contact and acculturation leading to changes in behavior and systems of meaning. Transnational

identities are becoming part of this changing world. Combining different cultural repertoires results in new or creolizing cultures. Personal identities are redefined, sometimes leading to a nostalgic recreation of what is considered as lost traditions, occasionally with fundamentalist characteristics.

An increasing number of children have parents with a history of migration. These next generations are confronted with new challenges: multiple identifications, conflicting loyalties, changes in intergenerational dynamics, and threats of social exclusion in societies that are their country of birth and their country of origin. The societal and political response to their problems and coping strategies can enhance their exclusion and contribute to psychiatric problems, or can result in new coping styles and resilience.

Cultural psychiatry and psychology are crossing borders too. Mental health care and psychosocial interventions are spreading around the world and exported to low-income countries and areas of conflict. The predominantly western classification system DSM is introduced all over the world alongside ICD. Research into the efficacy of psychopharmaceuticals is transplanted to low-income-countries and results assumed to have universal applicability. This raises questions of cultural validity and bias, of the relationship between western-based psychiatry and indigenous health care systems, of cultural hegemony and ethics, and of changing biological and social paradigms.

In these changing societies mental health professionals are facing the limitations of traditional classification systems, concepts and therapeutic repertoires. They too are challenged to develop

Continued page 37

**International Conference on
Transcultural Psychiatry
13 - 16 June, 2010
Amsterdam, the Netherlands**

From page 36

new conceptual approaches and treatment methods to enhance mental health and wellbeing, and to provide care to migrants and their children. In order to deal with the above mentioned societal changes and their influence on clients and communities we need to reflect on our clinical practices, our research agenda and maybe also on the position of mental health personnel in the public debate.

This congress addresses issues derived from this theme, and discusses them in relation with mental health care in the conference symposia and workshops.

Scientific Program

* Keynote speakers during the conference:

Devon Hinton: Cultural sensitive CBT for traumatized populations

Stevan Hobfoll: Conservation of resources model

Laurence Kirmayer: DSM-V and beyond

Batja Mesquita: Emotions

Fons van den Vijver: On identities

Joseph Westermeyer: Internalizing and externalizing disorders from a cross-cultural perspective

* Pre-conference courses on Sunday 13 June with

Abdessalem Yahyaoui: title to be announced

Laurence Kirmayer: The practice of cultural consultation

Stevan Weine: Ethnography in intervention development for families impacted by migration and trauma

Joop de Jong: Public mental health in low- and middle income countries

Stevan Hobfoll: Trauma, loss and traumatic growth

Devon Hinton: Cultural sensitive treatment of traumatized non-western populations.

* One full-day film program on Tuesday 15 June: films on public mental health and international ethnographic and psychosocial issues

* The theme of the TPS-chair's round table discussion is; "The culture of free-enterprise medicine and ethical conflicts in psychiatry."

* There will be 28 parallel symposia. The titles of some of the symposia can be found in the preliminary programme on the website: <http://www.tp2010.org>.

Call for abstracts:

Deadline 15 January 2010

Types of submissions:

Oral Presentation and Poster presentations.

Oral Presentation submissions will be organized in symposia by the scientific committee. Papers are appropriate for the full range of research and clinical reports, preferably completed projects related to the conference theme.

Social program:

* The opening ceremony on Sunday June 13th will be followed by a welcome reception

* Conference dinner on Tuesday 15 June

* Information on possible tour arrangements during and following the conference will follow later

Accreditation will be requested from EACC-MA, NVvP, NIP, FGzP.

Continued page 38

**International Conference on
Transcultural Psychiatry
13 - 16 June, 2010
Amsterdam, the Netherlands**

Registration fees: € 300- € 500,

We hope to see you all in Amsterdam,

Kees Laban, chair of the conference
Joop de Jong, chair of the scientific committee
Ron Wintrob, co-chair of the conference
Rutger Jan van der Gaag, honorary chair of the conference

From page 34

Venue:
Royal Tropical Institute (KIT), Amsterdam.

Migration, next generations and the future of psychiatry

13 - 16 June 2010



Keynote speakers

- Devon Hinton
- Stevan Hobfoll
- Laurence Kirmayer
- Batja Mesquita
- Fons van den Vijver
- Joseph Westermeyer

International Conference on Transcultural Psychiatry

**Royal Tropical Institute
Amsterdam, The Netherlands**

Conference secretariat


congress
company
P.O. Box 2428
5202 CK 's-Hertogenbosch
The Netherlands
Tel +31 (0) 73 700 35 00
Fax +31 (0) 73 700 35 05
info@tp2010.org

NETHERLANDS
PSYCHIATRIC
ASSOCIATION
Section Transcultural Psychiatry



WORLD PSYCHIATRIC ASSOCIATION
Transcultural Psychiatry Section

NETHERLANDS
PSYCHIATRIC
ASSOCIATION



Co-sponsored by:  Nordic Network for Cultural Psychology and Psychiatry (CPPN)

www.tp2010.org

1st Southern African International Conference on Cultural Psychiatry

Dates: 26-29 September 2010

Venue: Durban, South Africa. Durban is the multicultural capital city of the KwaZulu-Natal Province of South Africa. Located on the east coast of South Africa, temperatures are mild in September, and considered the best time to visit, with daytime maximum temperatures around 25 degrees Celsius

Theme: Cultural Psychiatry in Africa and across the World

Hosted by: Department of Psychiatry, Nelson Mandela Medical School and University of Limpopo (Medunsa Campus)

Conference co-sponsors: World Psychiatric Association, Transcultural Psychiatry Section and Section on Psychiatry in Developing Countries, and by the South African Society of Psychiatrists

Some of the conference's social program:

Sunday 26 September: Opening Reception

Tuesday 27 September: Gala Dinner

Wednesday 28 September: Closing Ceremony

29 September - 2 October: post Congress tours

Accommodation in Durban: There are hotels in all categories of comfort/luxury

Conference website: More detailed information will be available on the conference website that will be up and running by December 1, 2009.

For more information please contact Professor DL Mkize at mkizedl@ukzn.ac.za

Professor DL Mkize

Head : Department of Psychiatry

Nelson Mandela Medical School

University of KwaZulu-Natal

Durban, South Africa

Head: KwaZulu-Natal Mental Health Services

Chairperson: National Health Research Committee

President: College of Psychiatrists, Colleges of Medicine of South Africa

Email: mkizedl@ukzn.ac.za

1st International Conference on Cultural Psychiatry in the Spanish-speaking World

Title: Migration, Multiculturalism and Mental Health in the 21st Century

Dates: October 30 and 31, November 1, 2010

Conference venue: Facultad de Geografía e Historia de la Universidad de Barcelona, a new conference center located in the heart of the historic Old City of Barcelona

Plenary session speakers (tentative): Drs. Berrios, Obiols, Bennegadi, Achotegui and Vilaseñor

Principal themes of proposed symposia: psychopathology of migration, psychosocial aspects of migration, culture change and migration, and new lines of research about migration and mental health

Continued page 40

1st International Conference on Cultural Psychiatry in the Spanish-speaking World

From page 39

Social program: we are planning a reception at the Barcelona Municipal Council on the first day, a dinner at a typical Catalan restaurant on the second day, and a traditional Fiesta to mark the end of the conference

Tour arrangements planned: Gaudi monuments (Cathedral of the Holy Family, La Pedrera and others) the historic old city center of Barcelona, Montserrat

Society for the Study of Psychiatry and Culture & McGill University's Division of Social and Transcultural Psychiatry

Title: Rethinking Cultural Competence from International Perspectives

Dates: 29 April to 1 May 2010

Venue: Montreal, Canada

The meeting will be held at the newly remodeled Holiday Inn-Midtown, 420 Sherbrooke Street West, conveniently located across from the entrance to the McGill campus and near the Montreal Metro. As in the past, the registration fee will cover an opening reception, lunches on Thursday, Friday and Saturday, and two breaks per day on all three days.

Hotel rates are \$119/night, single or double occupancy, and include continental breakfast.

The number of rooms is limited, so please register early.

Topics:

- Unpacking the Metaphor of Cultural Competence
- Responding to Cultural Diversity in Primary Health Care
- Cultural Adaptation of Clinical Methods and Programs
- Innovations in Education and Training
- Internet-Based Resources for Multicultural Mental Health
- International Perspectives on Cultural Consultation
- Innovative Approaches to Cultural Competence, Safety and Responsiveness
- Trauma and Global Health
- New Developments/Research

Sponsors:

The conference is jointly sponsored by the Division of Social and Transcultural Psychiatry, McGill University and the Society for the Study of Psychiatry and Culture.

For more details on the conference please visit our website <<http://www.psychiatryandculture.org>>, and check for updates throughout the fall and winter.

Abstract submission:

To be considered, please submit your abstract to SSPC2010abstracts@gmail.com no later than January 15, 2010. All other communications should be sent to SSPC2010@gmail.com.

Please note that all papers will be peer reviewed. Please indicate whether you wish your paper to be considered for an oral presentation or a poster session.

Continued page 41

**Society for the Study of Psychiatry
and Culture
&
McGill University's Division of Social
and Transcultural Psychiatry**

From page 40

McGill Advance Study Institute:

The conference will be preceded on April 26-28 by workshops of the McGill Advanced Study Institute on Cultural Psychiatry. For more information and registration for the ASI, see: <http://www.mcgill.ca/tcpsych>

The hotel will offer its discounted rate for workshop participants starting Sunday night (April 25, 2010).

Introduction to the theme:

In recent years, cultural competence has become a popular term for strategies to address cultural diversity in mental health services. Alternative constructs that have been proposed include cultural safety, humility, sensitivity, responsiveness and appropriateness. Each of these metaphors draws attention to certain dimensions of inter-cultural work while down playing or obscuring others. Each perspective is rooted in particular constructions of cultural identity and difference that have social origins.

Approaches to cultural competence have been dominated by work in the U.S. which configures cultural difference in specific ways that reflect its history, demography, and politics. In New Zealand, cultural safety has been promoted as a term that draws attention to issues of power and vulnerability resulting from the history of colonization. Work in other countries has favored other models and metaphors to address diversity.

This conference will bring together an international group of clinicians, researchers and educators to critically assess notions of cultural competence in clinical care, research, and education. Sessions will be devoted to a conceptual analysis and critique of cultural competence, strategies for addressing cultural diversity in primary care, the relevance of culture in global mental health, the cultural adaptation of psychotherapy and other clinical interventions, pedagogical approaches to professional training, and ways to improve the cultural responsiveness and appropriateness of clinical services. The conference will conclude with a debate on the future of culture in mental health services.



MSc Mental Health Care & Transcultural Mental Health

Welcome to Transcultural Mental Health Care in the Wolfson Institute of Preventive Medicine at Barts and The London, Queen Mary's School of Medicine and Dentistry.

We offer postgraduate programme in Transcultural Mental Health Care leading to MSc, Postgraduate Diploma or Postgraduate Certificate qualifications.

This MSc in Transcultural Mental Health Care focuses on improving cultural capability in health and social care, and providing training in health services research. Students will develop a knowledge base derived from anthropological, medical, sociological, epidemiological, pharmacological and cultural understandings of the presentation, expression and management of psychological distress amongst black and ethnic minorities. Students undertake a placement for reflective practice, a research project/critical review, and regular tutorials and writing exercises on course content. The course is multidisciplinary, and we have established ourselves as a leading world centre offering an innovative curriculum.

Other work includes a study of work characteristics, stress and ethnicity; explanatory models of mental distress, mental health problems among Somali people, South Asians and common mental disorders, a survey of mental health problems among children and adolescents.

Please note that this is the provisional programme for the intended course to be delivered, but we reserve the right to change any aspect of the details outlined in this brochure should this become necessary through unforeseeable circumstances.

Duration

One-year full-time/two years part-time (for MSc).

Teaching method/Distance Learning

Lectures and PBL classes are run on Wednesdays.

The course is also now available by Distance Learning: please follow the link for detailed information (PDF, 31K).

Structure

- * Three 12 week modules (MSc)
- * *Two 12 week modules (Diploma)
- * *One twelve week module (Certificate)

(*Available at discretion of Programme Organiser and Examination Board)

Modules

- Module 1: Mental Health Assessment
- Module 2: Transcultural Mental Health / Psychological Therapies
- Module 3: Research in Transcultural

Mental Health Definitions

In this MSc any one module encompasses four course-units (120 hours each, a total of 480 hours per module). At the discretion of the programme organiser and the examinations board, those not completing the programme of study for the Masters may be eligible for the award of a Postgraduate Diploma or Postgraduate Certificate.

Module 1 must be completed for the award of a Postgraduate Certificate.

Modules 1 and 2 are necessary for the award a Postgraduate Diploma.

Continued page 43

MSc Mental Health Care & Transcultural Mental Health

From page 42

Modules 1,2 and 3 are necessary for the award of an MSc.

Enhancing knowledge, skills and career prospects.

Students will learn to improve their assessment of mental health problems. This is now a core competency, since the development of community care where multiple professions have to be responsible for the assessment and management of mental health problems in different cultural groups. The specific strength of this MSc is that, students will develop a knowledge-base derived from social anthropological, medical, sociological, epidemiological and pharmacological understandings of the presentation, expression and management of distress amongst black and ethnic minorities. Masters students will also learn of the methodological problems in conducting research and will develop at least one research proposal, conduct a pilot study and undertake at least one piece of research work during the MSc. They will be encouraged to do this in a collaborative format demonstrating the strengths and value of working in manner that is now considered necessary to achieve high quality outcomes for research.

Students will complete original research work, and will be encouraged to publish and disseminate their work.

Application forms can be obtained from:
The Graduate School Office,
Tel: +44 (0)20 7882 5377,
Fax: +44 (0)20 7882 5588
email: pgsmd@qmul.ac.uk

MSc Mental Health: Transcultural Mental Healthcare/Psychological Therapies



 **Barts and The London**
School of Medicine and Dentistry

**Centre for Psychiatry
Wolfson Institute of
Preventive Medicine**

MSc in Culture and Health, 2010-11

UNIVERSITY COLLEGE LONDON
Division of Population Health
Department of Mental Health Sciences



This unique course, one year full time or two years part time, is taught by leading Clinician Anthropologists working at the cutting edge interface of Medicine and Anthropology. The aim of the MSc is to provide an advanced education in the concepts and theory of cross-cultural psychiatry and medicine, along with methods and techniques required for research in this area. Besides the understanding it offers of health issues, a primary focus of the MSc is research in other cultures and with minority groups in Britain and abroad. Students can choose to study either mental or physical health. The course is distinctive in that it debates and teaches the application of principles of medical anthropology into clinical practice, and is ideal for those wishing to work in the health services or pursue a PhD in cultural psychiatry. There will be an additional option for students on the mental health stream to train in Intercultural Psychotherapy upon completion of the UCL MSc. This course will be taught in collaboration with Nafsiyat Intercultural Therapy Centre. Successful completion of the Nafsiyat Intercultural psychotherapy course will enable participants to gain a professional psychotherapeutic qualification to work effectively and competently in a culturally diverse society.

Modules include: 1) Introduction to Cultural Psychiatry 2) Introduction to Culture & Physical Health 3) Research Methodology in Culture & Health 4) Medical Anthropology 5) Anthropology & Psychiatry 6) Religion & Health 7) Cultural Psychiatry: Clinical Application 8) Nafsiyat psychotherapy course

Applicants must have, or be likely to obtain, a good honours degree in medicine, psychology, anthropology, counselling, or related area (first or upper second), or a recognized professional qualification in clinical psychology, social work, nursing, occupational therapy or their equivalent.

For a prospectus and application form please contact the Course Administrator, MSc in Culture and Health, Department of Mental Health Sciences, UCL, 2nd Floor, Charles Bell House, 67-73 Riding House Street, London W1W 7EJ.

Tel: 020 7679 9452
Fax: 020 7679 9426
Email: a.charles@ucl.ac.uk

For further academic information contact:
Dr. Sushrut Jadhav at [<s.jadhav@ucl.ac.uk>](mailto:s.jadhav@ucl.ac.uk) or
Dr. Simon Dein at [<s.dein@ucl.ac.uk>](mailto:s.dein@ucl.ac.uk) or
Professor Roland Littlewood at [<r.littlewood@ucl.ac.uk>](mailto:r.littlewood@ucl.ac.uk)